



# PRACTICAL GENERAL PRACTICE



# PRACTICAL GENERAL PRACTICE

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## Disclaimer

The clinical advice and the organisational details contained in this book refer to the United Kingdom, unless



way round the present compromise and ask that you excuse our inconsistency. Our move to an international version is not due to unbounded ambition, but to our realisation that previous editions have sold well abroad, and that we need to respond to what is clearly a need in

countries other than the UK. Indeed, the book has already been translated into Spanish.

Alex Khot  
Andrew Polmear

- s e s e

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Central to the structure are instructions preceded by an asterisk:

- \* Ask the patient x, y and z;
- \* Examine for a, b and c;
- \* Take blood for d, e and f, etc.

At the same time the reasons for these steps are explained, either in the same sentence or above, signalled by a round bullet:

- | Patients with x are...
- | Treatment can be expected to ...
- | Nurses are better than GPs at ...

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Where we present a list in no particular order we use

- (a) chest pain; or
- (b) hypotension; or

We would like to thank the staff at Butterworth-



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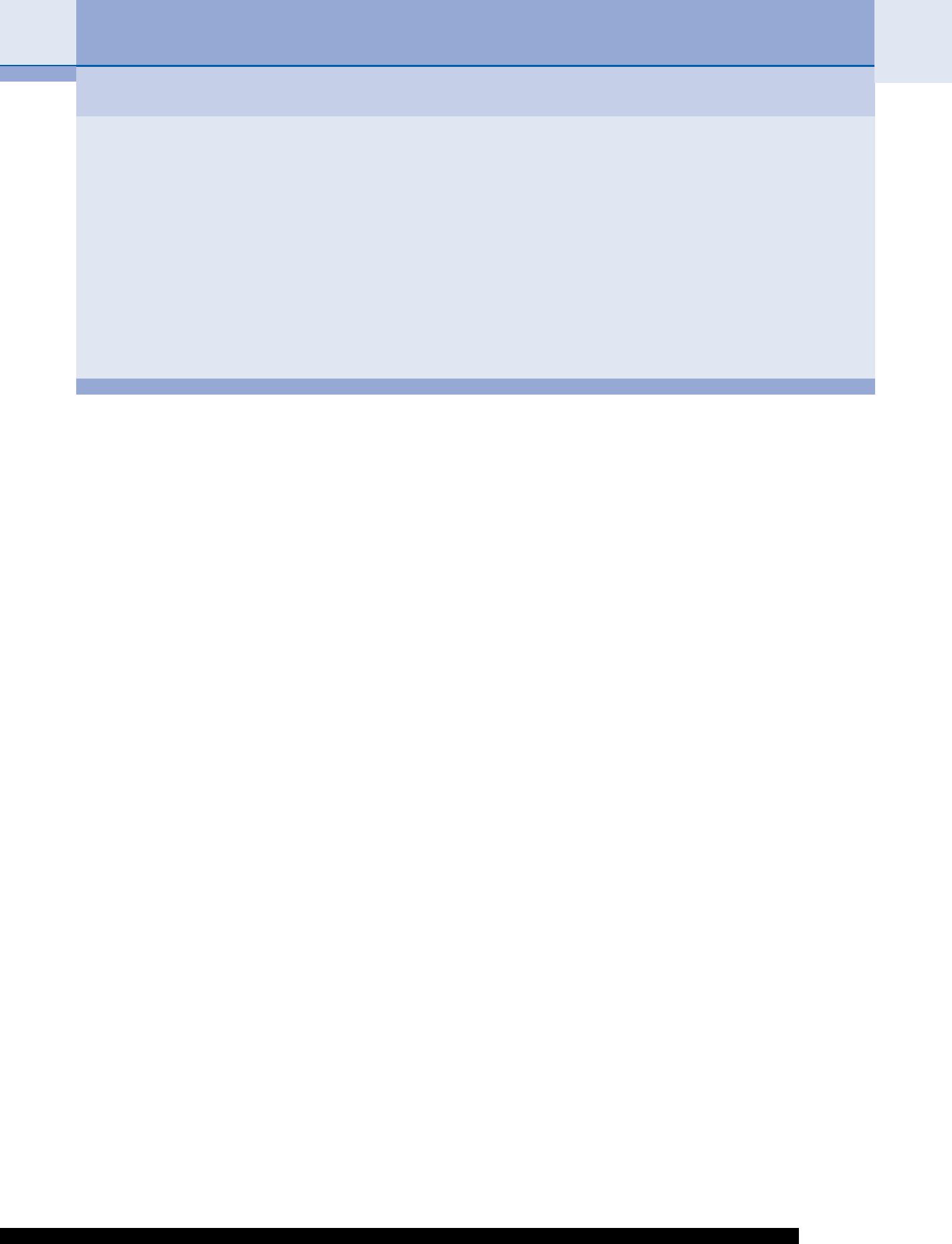
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Rehabilitation





IQ	intelligence quotient
ISA	intrinsic sympathomimetic activity
ISDN	isosorbide dinitrate
ISMN	isosorbide mononitrate
ITP	idiopathic thrombocytopenic purpura
iu	International Units
IUCD	intrauterine contraception device
IUD	intrauterine device
IUGR	intrauterine growth retardation
IUS	intrauterine system
iv	intravenous
IVU	intravenous urogram
JVP	jugular venous pressure
KUB	kidneys, ureter and bladder
LBC	liquid-based cytology
LDL	low-density lipoprotein
LFT	liver function test
LH	luteinizing hormone
LHRH	luteinizing hormone releasing hormone
LMP	last menstrual period
LNG-IUS	levonorgestrel releasing intrauterine system
LOC	loss of consciousness
LR	likelihood ratio
LSCS	lower segment caesarean section
LTOT	

RCP	Royal College of Physicians
RCT	randomized controlled trial
RDC	research diagnostic criteria
REM	rapid eye movement
RIDDOR	Reporting of Injuries, Disease and Dangerous Occurrences Regulations
RMO	Regional Medical Officer
RMS	Regional Medical Service
RNA	ribonucleic acid
RR	relative risk (according to context)
RR	

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that the employer can judge the feasibility of the patient's returning to work.

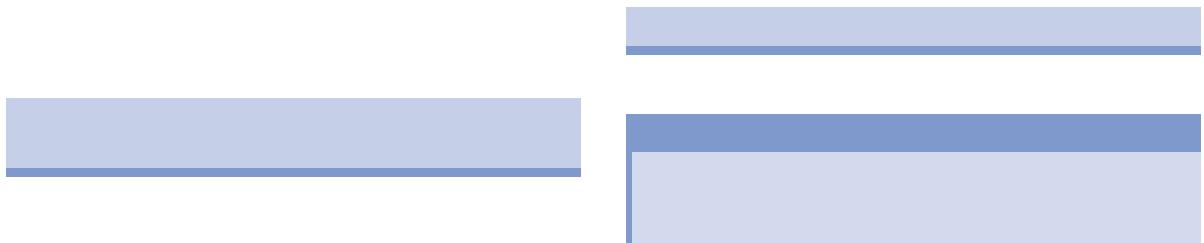
For how long may the statement be issued?

The doctor states the duration of the period in which the patient is unfit for work either:

- (a) by stating a period of time, which may be for no more than 3 months at a time in the first 6 months of illness, but which may be for a period of any length after the first 6 months, including for 'an indefinite period'; or
- (b) by specifying a start and end date. This may be done if:
  - the statement covers a previous period when no statement was issued; or



than £92 a week (2009) while working for fewer than 16 hours a week. Prior approval



- 
- \* A form Mat B1(A) should be issued either by the GP or by the midwife not earlier than 20 weeks before the expected week of delivery (i.e. after 20 weeks of pregnancy). Examination may have been before this time.
  - \* If maternity allowance is claimed after confinement, use form Mat B1(B).

Health and Safety Executive.

- aged  $\geq$  16 and either disabled or looking after a child, and working > 16 hours a week.

Contact the Tax Credit Helpline on 0845 300

3900 or [www.taxcredits.inlandrevenue.gov.uk](http://www.taxcredits.inlandrevenue.gov.uk)

- (g) Certain NHS benefits: free prescriptions, dental treatment and sight tests, vouchers for glasses. Help with hospital travel costs can be claimed directly from the hospital if the patient has proof of eligibility, or via the Jobcentre Plus.

(h)



Armed Forces and for certain other categories injured or disabled because of war. In addition to the pension, the disabled person is entitled to priority treatment for the disability from the NHS and payment of funeral expenses if death is due to the disablement. There is provision for a widow or widower's pension, and allowances for children, parents and other relatives in certain circumstances.

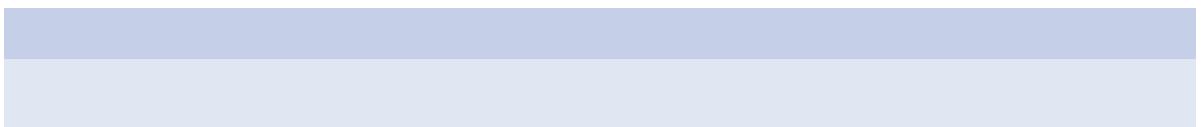
- (i) Criminal Injuries Compensation. The injury must be severe enough to need sutures or to have caused a fracture, or hospital admission, and can include compensation for mental injury. Minor injuries, such as scratching or bruising are unlikely to qualify but a combination of minor injuries may if they last for at least 6 weeks and necessitate at least two visits to a doctor. Patients should apply to the Criminal

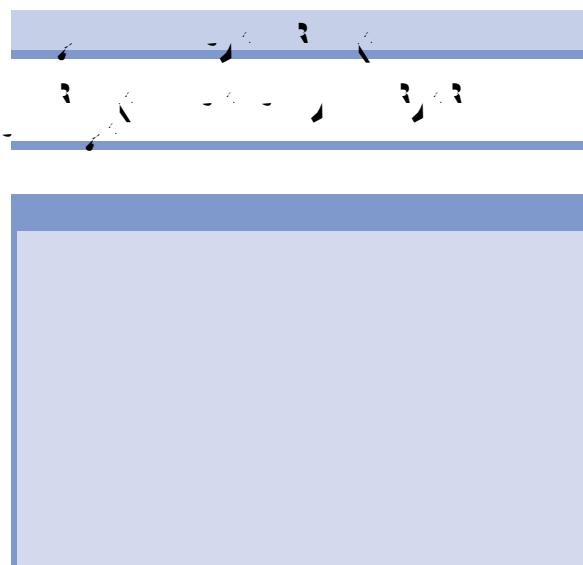


Longview Road, Swansea SA99 1TU, tel. 01792









their GP for advice about their suitability.

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warn airport security staff if carrying needles, syringes or lancets.

- | Patients who fly frequently can obtain a frequent traveller's medical card (FREMEC), which will be recognized by many airlines. This saves completing new forms for every flight and means that the airline will know what assistance will be needed at the airport and on board.

|







- (o) psychiatric difficulties;
- (p) obesity (BMI)



- | Where nursing or paid care is provided, the nurse or paid carer will be the decision-maker.
- | If a Lasting Power of Attorney (or Enduring Power of Attorney) has been made and registered, or a deputy has been appointed under a court order, the attorney or deputy will be the decision-maker, for decisions within the scope of their authority.
- | If the decision involves the drawing up of a care plan, a team may make the decision.

Who should be consulted when a major decision is made on behalf of a person without capacity?

- | Anyone the person has previously named as someone they want to be consulted;pe of their authority.



remains valid even if the donor becomes mentally incapable.) These powers of attorney only cover financial matters, not, for instance, consent to treatment; or

- a Lasting Power of Attorney (LPA) introduced in 2007. As well as property and affairs (including financial matters), LPAs can cover personal welfare (including healthcare and consent to medical treatment) for people who lack capacity to make such decisions for themselves. Attorneys must still make decisions in the person's best interests, as above.

For an EPA or LPA the donor must understand:

- (a) that the attorney will be able to assume complete authority over the person's affairs;
- (b) that the attorney will be able to do anything with the donor's property that the donor could have done;  
*tosappe*

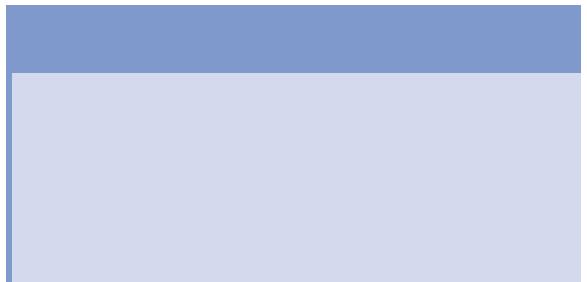
This is required when a doctor examines, investigates

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civil partners can acquire parental responsibilities in the same way. Divorce makes no difference to a parent's rights.

Only one parent need give permission but in



- \* Ensure privacy.
- \* Offer a woman a female doctor or chaperone if she has been assaulted by a man.
- \* Check whether the patient intends to report the assault to the police. Respect the patient's decision, except in the case of child abuse, which must be reported. Explain that reporting is necessary if the victim wishes to claim Criminal Injury Compensation.
- \* Discuss whether the patient is safe to return home. If not, recommend a woman's refuge (via the duty Social Worker) or urgent homeless accommodation from the Council Housing Department.
- \* For legal purposes:



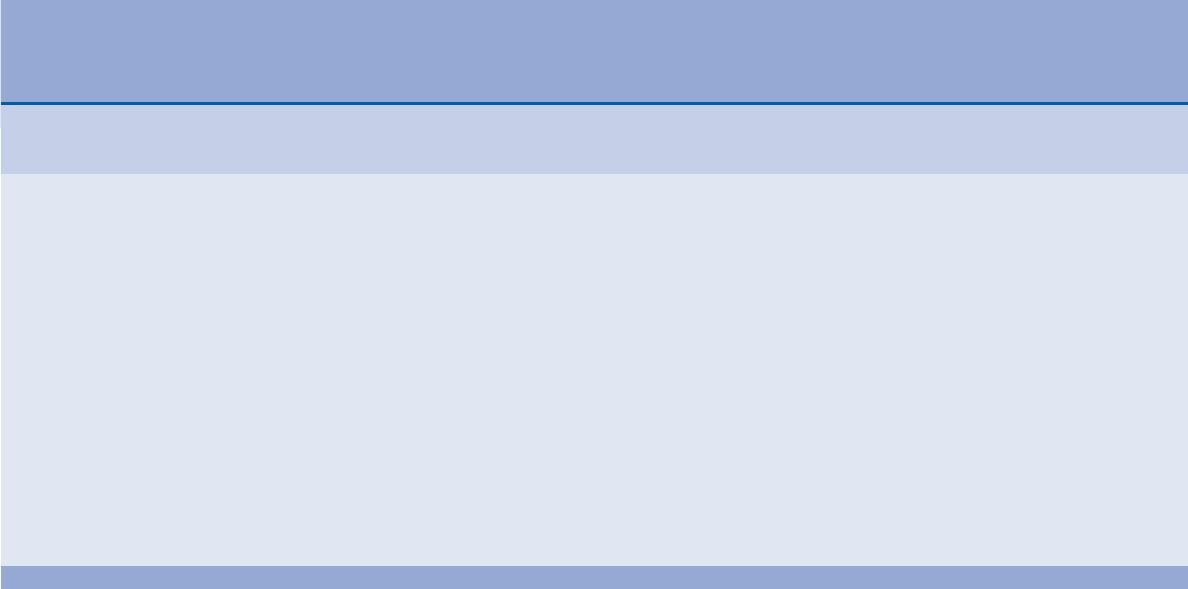






- (b) Attempts by the patient to remedy her situation (for example, through police, courts, separation, refuges, and so on).
- (c) Sources of emotional support.
- (d) The current living situation. Is there some place, other than home, where she can go to recuperate if it is dangerous for her to return home?
- (e) Present danger:
  - Is the abuser verbally threatening her?
  - Is the abuser frightening friends and relatives?
  - Is the abuser threatening to use weapons?
  - Is the abuser intoxicated?
  - Does the abuser have a criminal record?
  - Are the children in danger?





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Immunisation Against Infectious Disease 2006 (known as the 'Green Book'), published by the DoH, the Scottish Home and Health Department and the Welsh Office. Available from The Stationery Office, PO Box 29, Norwich NR3 1GN and authorized bookshops and from [www.tsoshop.co.uk](http://www.tsoshop.co.uk). The full text





least 1 month, or adults who have received the equivalent of 40 mg prednisolone per day for > 1 week or 20 mg/day for at least 1 month. Lower doses may suppress immunity, especially if combined with cytotoxic drugs. Discuss each case with the specialist concerned;

- patients on biological therapies e.g. infliximab;
- patients with malignancy of the reticuloendothelial system;
- patients who are immunosuppressed due to radiotherapy or chemotherapy in the last 6 months, or are in some other way immunodeficient.

(c) within 3 weeks of each other. If they must be given within 3 weeks, they should be given on the same day. This is, however, only based on the observation that smallpox immunization may be less effective if (based)-3271616lo

eachreticanTf11.507.vacc0.itsssedunavoidableleasedmay beinflixim9(given)-33



- \* Give Hib, influenza, MenC and pneumococcal vaccine.
- \* Give oral phenoxyethylpenicillin prophylaxis against streptococcal and neisserial infection.

The lifetime risk of overwhelming infection post-splenectomy seems to be 5%. Most of these are preventable (Newland, Provan and Myint 2005).



- \* Give pneumococcal vaccine.





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If possible, live viruses should be given at least 3 weeks before or at least 3 months after. This does not apply to yellow fever vaccine.



those with learning difficulties (50% of Down's syndrome inpatients, for instance, may be



\*



\* Obtain consent to the test only after these issues

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- (c) Arthralgia or arthritis occurs rarely 2–3 weeks after immunization.
- (d) Meningoencephalitis due to the mumps component occurred in 1:400,000 cases until 1992, when the mumps virus strain was changed. No cases have been reported since.
- (e) Thrombocytopenia



washes for the body and hair with shampoo  
(e.g. chlorhexidine or triclosan) daily for 5 days,  
chlorhexidine or mupirocin nasal cream t.d.s. for  
5 days, and hexachlorophene powder to axillae  
and groins if they carry the organism (



High-risk groups are those with:

- (a) asplenia or severe splenic dysfunction;
- (b) HIV infection or other cause of immunodeficiency, including adults on, or likely to be on, systemic steroids equivalent to prednisolone 20 mg daily for > 1 month;

(c)

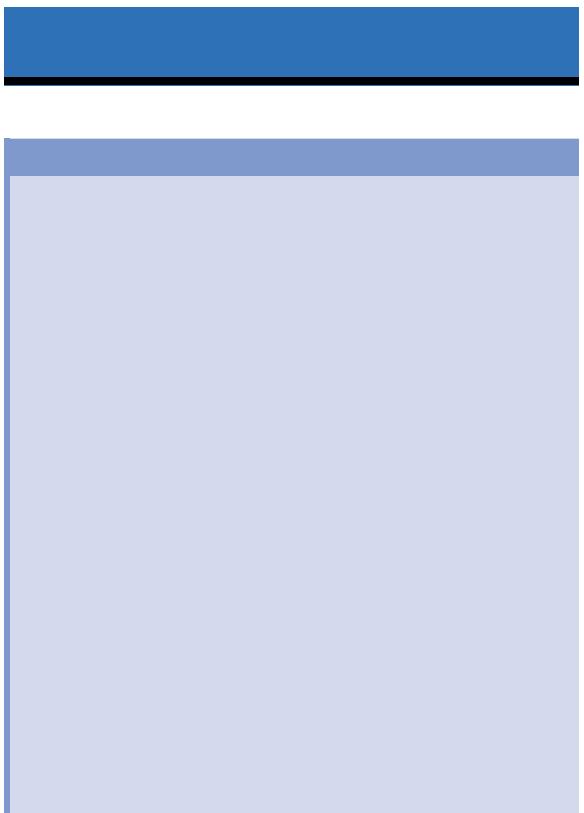


primary immunization only if they were born in the UK after 1960, or were in the Armed Forces in or after 1938.



- \* Refer to a chest clinic, where a tuberculin test will be performed before administering BCG except in infants and young children.
- \* Once BCG has been given, do not use that

is not known to be immune. Check maternal serology before giving immunoglobulin. (There is no risk to the baby if the mother develops zoster, since she clearly has had chickenpox in the past and the



of that country. Note that this will not necessarily cover all the cost nor extra items, such as repatriation back to the UK for which insurance is still needed. It will not cover the traveller at all if the main purpose of the trip is to obtain treatment.







(a) cover arms and legs from dusk till dawn  
when out of doors;

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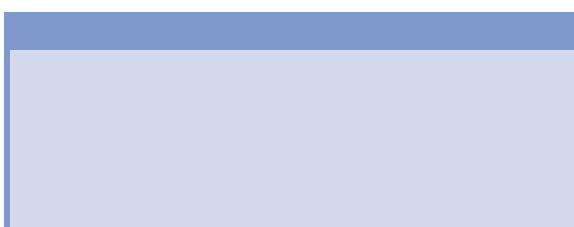


high-risk area, especially those in contact with local people, e.g. aid workers or backpackers. Childhood immunization against meningococcus group C offers little protection. The risk among conventional tourists, even in high-risk areas, is very low.

- | Travellers entering Saudi Arabia for the pilgrimage to Mecca must provide proof of vaccination with meningococcal ACWY vaccine. Even those with a current certificate of vaccination against meningococcal A and C need to be vaccinated against W and Y strains if going on the pilgrimage.



[www.nathnac.org](http://www.nathnac.org). Enter the site and click on the link to 'Yellow Fever Centres'. Travellers in whom the immunization is contraindicated need an exemption certificate in order to enter those



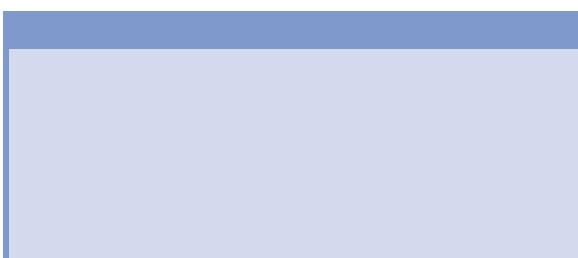
12 months after exposure. Vivax may cause illness as late as 18 months after return.

- \* Assume that fever in a traveller from sub-Saharan Africa is due to malaria until proven otherwise. Malaria can be contracted by patients in an aircraft on the runway in an endemic area. Malaria does exist even in countries for which prophylaxis is not recommended, e.g. the North African coast.
- \* If the first blood film is negative, continue to send blood films at least daily for 3 days unless the fever abates or another diagnosis is reached.

\*









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et al., 1993. Post-tropical  
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307, 541.
- Chen, L.H., Wilson, M.E.,  
Schlagenhauf, P., 2006. Prevention  
of malaria in long-term travellers.  
JAMA 296, 2234–2244.
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2001 (PL/CMO/2001/4). <http://www.doh.gov.uk/cmo/cmoh.htm>.
- CMO, 2001b. CMO's letter 9 March  
2001 (PL/CMO/2001/1). <http://www.doh.gov.uk/cmo/cmoh.htm>.
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2002 (PL/CMO/2002/1). <http://www.doh.gov.uk/cmo/cmoh.htm>.
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immunisation for health care  
workers. CMO's letter.  
Department of Health.
- CMO, 2004a. CMO Update.  
Department of Health, London.  
<http://www.dh.gov.uk/cmo>.

- Norboo, T., Ball, K., 1988. High altitude pulmonary oedema in the Himalayas: a preventable condition. *Practitioner* 232, 557–560.
- Phillips-Howard, P., Blaze, M., Hurn, M., Bradley, D., 1986. Malaria prophylaxis: survey of the response of British travellers to

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(d) Those presenting with a possible STI-related

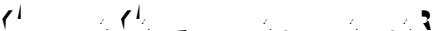






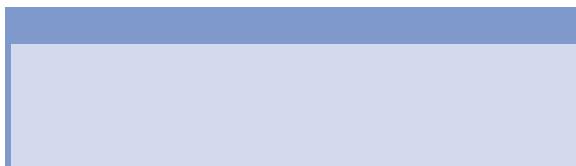


- \* Admit patients with urinary retention, meningism or severe systemic symptoms.
- \* Offer counselling, including a discussion of the risk of asymptomatic shedding and its implications for relationships, and the need to inform healthcare workers in the case of later pregnancy. Health advisers at the GUM clinic are experienced in this area.



- | Most recurrences cause minor symptoms, of a few days duration.
- | Severe recurrences may be shortened by oral antiviral agents as above. There is no evidence

Dam,19|cks10(gsav TDd)-eien130(r,19(vit2ardut2ar3he18(t)-741m [(M7anchi)1cng)1s h)-74)-3)1s 0ht2ar3vt2ario3it21( /T1\_3 1 T imp0845nced r/(expericM17srkershelrviM17UPPOR.4646 5GROUPthi 7 1gLoeral)-gli4 95rg 5 42.5197 ADVISINGd ar56v2(advl)-gl274.97.4718(above.4718((V,S2 gsA458.418S2 gsrck-332(evidence)]TJ T\* 28652425 177.077(abo1



is now recognized as a mainstay both of transmission prevention and of clinical care.

HIV testing is now recommended on GP registration in high prevalence areas (mainly London, see [hpa.org.uk](http://hpa.org.uk) for details), and for a range of 'indicator diseases' in which HIV is much more likely than in the general population. These indi-

## **R E A D Y**

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### **• S T R E S S**

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- \* Discuss any concerns that have given rise to the test, and how the patient plans to protect him- or herself in future. Discuss the window period and whether further testing will be needed for full reassurance.

### **• S T R E S S**

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- \* Ensure that you have time and there will be no interruptions to the interview. Tell the patient early in the interview, to allow time for reflection and questions.



cytomegalovirus (CMV) antibodies and toxoplasma antibodies should be assessed at baseline. Lipids, blood sugar, calcium/phosphate and possibly other monitoring tests

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[REDACTED]

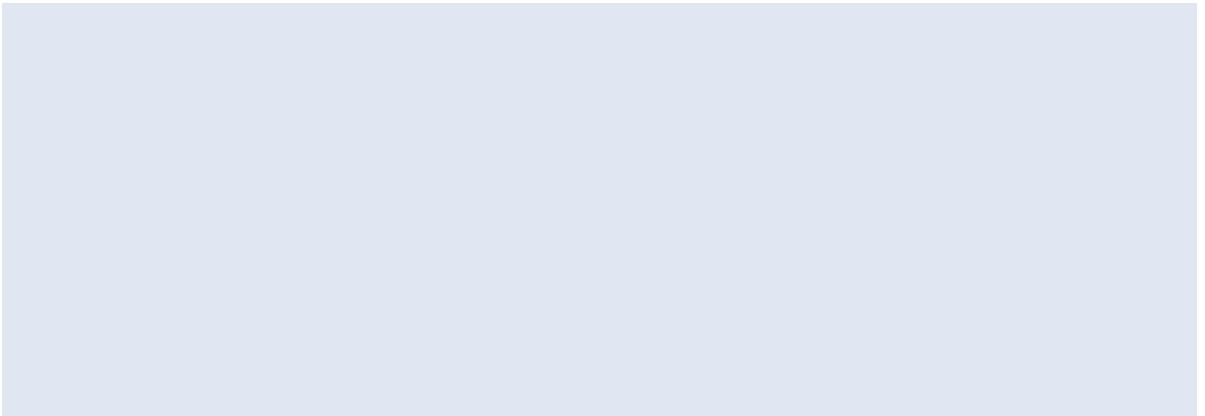
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The Committee on Medical Aspects of Food and Nutrition Policy 2000 (COMA) recommends that:

- (a) breastfeeding should be encouraged for 6 months, preferably longer;

(b)

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[REDACTED]

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relocates. In either situation, refer to an



Charts and measuring equipment are available from:

- (a) the Child Growth Foundation, 2 Mayfield Avenue, London W4 1PW, tel. 020 8995 0257 or 020 8994 7625, [www.childgrowthfoundation.org](http://www.childgrowthfoundation.org)
  - (b) [www.health-for-all-children.co.uk](http://www.health-for-all-children.co.uk)
- 

- \* Check weight: at birth, then regularly at routine well baby checks. Too frequent weighing may pick up small fluctuations and increase anxiety. The latest Hall report (Hall 4) recommends weighing and plotting at immunizations, at 8,
- 
-

hearing bringing this figure to 1.3 per 1000.

(These children need a hearing aid.)

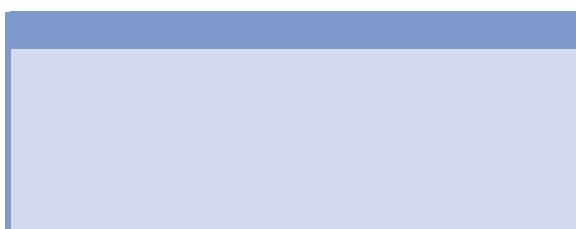
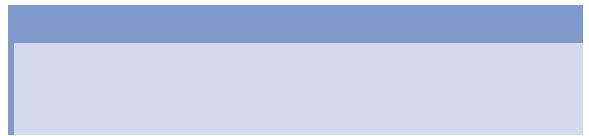
- | At least a further 0.3 per 1000 have a hearing loss which is less than 40 dB but is sufficient for the child to need a hearing aid.

|





- 
- | Communication impairments:
    - (a) abnormal language development especially muteness and inappropriate rhyming;
    - (b) echolalia;
    - (c) use of the third person to refer to oneself;
    - (d) limited vocabulary for age or social group;
    - (e) limited language in communication.
  - | Social impairments:
    - (a) inability to join in with or play with other children, inappropriate attempt at joining in (disruptive or aggressive behaviour);
    - (b)
- 
- 









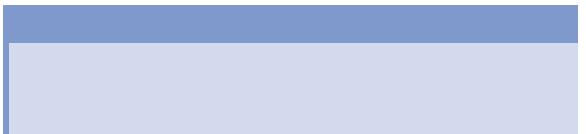
The symptoms of neglect and emotional abuse vary with the age of the child and may include:

(a) infants:



Order. A Supervision Order can apply for a maximum of 3 years, but is usually reviewed regularly. It does not give the local authority parental respon-

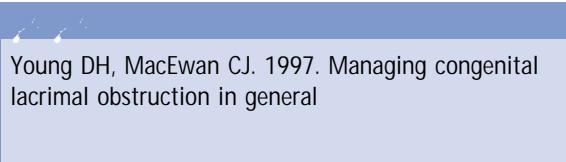
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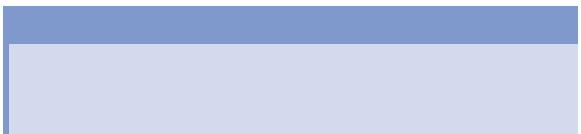
Young DH, MacEwan CJ. 1997. Managing congenital  
lacrimal obstruction in general



Dalby-Payne J, Elliot E. 2007. Gastroenteritis in

## Clinical presentation

- Oral rehydration salts (ORS) are used



likely to be temporary. No other food containing milk should be given. The advice of a dietician is recommended. Refer to hospital outpatients if symptoms have not resolved after 6 weeks.





- (b) a child over the age of 6 months with a history of a non-febrile convulsion who, when seen, is well (check the blood pressure and examine the fundi).

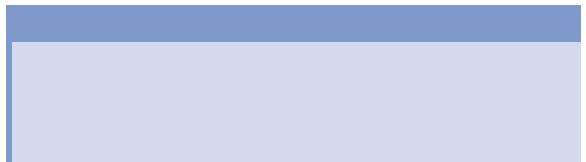
Note:





Soiling is abnormal after the age of 4 years. The majority of soilers are constipated, with a loaded rectum.

- \* Distinguish, from the history, between encopresis (normal stool passed in the wrong place) and soiling (leaking liquid stool into pants).
- \* Enquire as to:
  - (a)





condition their parents to respond. The child may receive feeds or other attention, and this perpetuates the cycle.

There is some evidence that 'controlled crying' (see below) reduces infant sleep problems and maternal depression at 2 months after starting but not at 4 months (





Lozano JM. 2007. Bronchiolitis. Clinical Evidence. BMJ Publishing Group, London

A diagnosis of 'probable bronchiolitis' can be made if an URTI occurs with:

- (a) progressive dry cough in an ill infant;
- (b)

The treatment of these two patterns is different.  
Children with pattern (a) do not require inhaled  
steroids unless the episodes are very frequent



Life-threatening features are:

- (a) cyanosis;
- (b) a silent chest;



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This strategy will clear new Pseudomonas infection in more than 50% of children. Chronic Pseudomonas infection requires long-term nebulized antibiotics.











(d) The timing of the pain varies, but tends to be less frequent at weekends and during school holidays.

\* Examine the child fully, plot the height and







These usually present in the first 3–4 months of life  
and are less common with increasing age.

\*



only if there is difficulty passing urine or if a full



- (b) the legs are asymmetrical;
- (c) there is anterior curvature of the tibiae;
- (d) if in bow legs the knee to knee distance is greater than 3 cm; or
- (e) if in knock knees the medial malleoli are more than 7 cm apart when the child lies down with the knees together and the patellae facing forwards. Referral might be made at lesser measurements if the distance is increasing.

\* Referral might be made if there is muscle weakness or a lack of movement at the tarsal joints.





- (b) having easily accessible health promotion material that covers emergency contraception and young people's legal rights to contraception;
  - (c) offering contraceptive methods that are attractive to young people (e.g. flavoured condoms), useable just at the time of intercourse, and cheap and easily obtainable;
- (d)
- 
-









(b)



- (c) the patient has evidence of target organ damage which is greater than would be
- 



energies on more worthwhile strategies (at least



- (a) women of childbearing potential;
- (b) patients with high sympathetic drive;
- (c) patients with another reason to need a beta-





stenosis or chronic kidney disease. Above that, reduce or stop the drug and recheck

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secondary hypertension, and a genetic resistance to the antihypertensives being used.

- \* Check that this is true resistance, not poor adherence or the white coat effect.



be offered treatment, starting with a beta-blocker, unless contraindicated. One contraindication specific to angina is the presence of Prinzmetal angina, that is, vasospastic angina occurring at rest. It is worsened by beta-blockade and relieved by dihydropyridine calcium-channel blockers.

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- \* Consider a trial of a tricyclic antidepressant or SSRI in a patient sufficiently troubled by pain, even in the absence of depression.



myocardial work. Do not give if the pulse is over 100, or the systolic BP is under 90.

- \* Oxygen: give 100% oxygen routinely.
  - \* Bradycardia: if the pulse is below 40, give atropine 300 mcg i.v. and further doses of 300 mcg if needed, up to 1.2 mg, whether the bradycardia is due to heart block or to sinus bradycardia. If the pulse is between 40 and 60, only give atropine if there is evidence of low cardiac output.
  - \* Aspirin: give 150–300 mg, either in a chewable or dispersible form. This gives 38 fewer major vascular events per 1000 patients at 1 month (NNT 27) (Antithrombotic Trialists' Collaboration 2002).
  - \* Defibrillation: defibrillate a patient who develops ventricular fibrillation while awaiting transfer to hospital. If no defibrillator is available, perform cardio-pulmonary resuscitation while waiting for one to arrive. Approximately 5% of patients experiencing an acute myocardial infarction develop cardiac
- 
- 
-



Occasionally a patient with a MI will refuse admission, or the decision will be made to keep the patient at home because of other circumstances. More frequently, a patient will be discharged early







heart failure in 70% of a cohort with dyspnoea or oedema when only 25% were finally judged to have heart failure (



**Patients of all classes should be given an ACE**

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- 
- \* Mobilization is advisable in theory but rarely practicable at this stage.
  - \* Diuretics. Avoid increasing diuretics at this stage unless doing so gives symptomatic relief. They are unlikely to have much effect on the oedema.
  - \* Be cautious about advising the patient to raise the feet. This may increase the venous return to the heart and worsen the dyspnoea.
  - \* Compression stockings/bandages. These may increase tissue damage and are uncomfortable.
- 

When called urgently to the patient in extremis, get

show evidence of pre-excitation, QT prolongation, ventricular hypertrophy or an old, or even recent, myocardial infarction.

- \* Ask the patient to tap out the rhythm. This may help to decide whether the arrhythmia is regular or irregular. However, patients are surprisingly poor at reporting details of their arrhythmia.

\*



- | The decision about whether to take warfarin or aspirin must be made with each patient and based on his or her risk, see Table 5.6. When patients are given information about their risk, roughly half the patients wish to take, or not take, warfarin in a way that is contrary to current guidelines (Protheroe, Fahey, Montgomery and Peters 2000).
- | The INR should be controlled to between 2 and 3. An INR below 2 does not reduce the risk of intracranial haemorrhage while an INR of 3.5–3.9 has an odds ratio (OR) for intracranial haemorrhage of 4.6 (compared to an INR of 2–3). The OR for intracranial haemorrhage with an INR of 4 or over is 8.8 (Fang, Chang and Hylek 2004). A simpler scoring system has been developed, called CHADS, or originally CHADS<sub>2</sub> to remind the user to score 2 for a history of stroke (Gage, Waterman,arehistlc(Tm[(3TJ-120TBon-493(o6.6322311.47614and)-250esk)-82(al.493(o6.6362311.2.25331(When)-1.127Tc skroughlTIA:olled to betw-7sho14ween 2 and 3.l





- The prevalence is 0.4% of the population and 5%



If the patient is seen during the attack:

- \* Get the patient to perform a Valsalva manoeuvre. A quick move from standing into a squatting position will have the same effect.
- \* Apply carotid sinus massage except where the patient:
  - (a) is elderly; or
  - (b) has ischaemic heart disease; or
  - (c) is likely to be digoxin toxic; or
  - (d) has a carotid bruit; or
  - (e)

The two guidelines in the box above disagree







Familial hypercholesterolaemia is present in 1 in 500 of the population in the UK and for men carries





the risk of MI is halved (Wannamethee, Shaper and Walker 1998) with less risk of death if it does occur, but this benefit is lost if exercise is stopped. Exercise continued for over 1 year improves the coronary collateral circulation enough to be demonstrable on a thallium scan.

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\*



- Offer a statin regardless of baseline cholesterol level.
- Start with simvastatin 40 mg daily, or 80 mg daily in those with acute coronary syndrome.
- Recheck the serum lipids after 3 months.  
If TC  $\geq$  4 mmol/l or LDL  $\geq$  2 mmol/l consider offering to increase simvastatin to 80 mg daily. If targets are still not reached, add ezetimibe. Other options are a fibrate,



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Aboa-Eboule, C., Brisson, C.,  
Maunsell, E., et al., 2007. Job strain  
and risk of acute recurrent  
coronary heart disease events.  
JAMA 298, 1652–1660.  
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DTB, 1990. What to do about pulmonary heart disease. Drug Ther. Bull. 29, 90–92.

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review of the evidence. Br. J. Gen.  
Pract. 52, 47–55.
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aldosterone receptor antagonists.  
Clin. Evid. Dec(12), 115–143.
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Watson, R.D., et al., 1983. The  
effect of nifedipine on arterial  
pressure and reflex cardiac  
control. Circulation 68(1), 115–143.











and Jones 2003). They are less effective than inhaled steroids in the management of mild persistent asthma (Adams, Bestall, Malouf 2005; Haahtela, Jarvinen, Kava et al., 1991).

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1. Consider an objective trial of long-acting bronchodilators.
  2. Monitor response with symptoms and peak flow charting.
  3. If no response, stop the additional therapy and consider an alternative (e.g. leukotriene antagonists, increased dose of inhaled steroid).
  4. If poor response to any of the options, consider the need for referral.
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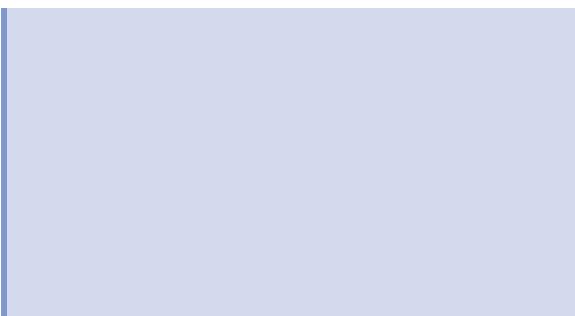
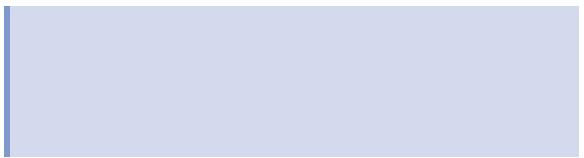
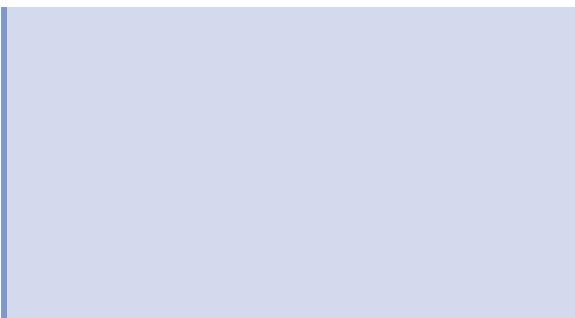
Referral to a respiratory physician or paediatrician should be considered if (British Thoracic Society/ Scottish Intercollegiate Guideline Network 2008):

- (a) the diagnosis is not clear;
- (b)

**2. Instructions**

(a)





Guidelines Network 2002; British Thoracic Society 2001; National Institute for Health and Clinical Excellence 2008).

- 
- \* Examine the chest. The presence of localized chest signs is positively correlated with radiographic
-

- (d) Prescribing antibiotics did not reduce the reconsultation rate in a UK primary care study (Holmes, Macfarlane, Macfarlane et al. 1997).
  - (e) Declining the request for antibiotics and educating patients on the limitations and disadvantages of treatment is effective in reducing antibiotic use (Gonzales, Steiner, Lum, Barrett Jr)
- 



chronic heart disease, neurological disease, diabetes, alcoholism, chronic renal or hepatic failure;

- (c) asplenic and immunosuppressed patients.
- | Pneumococcal vaccination is recommended for the last two of these three categories.



The aim of the management of patients with COPD is to make an objective diagnosis as early as possible in the course of the disease in order to encourage smoking cessation and prevent progression. Treatment is aimed at providing the best possible relief of symptoms and improving quality of life. As the disease progresses, treatment levels and professional support should be stepped up to provide adequate palliation (National Institute for Clinical Excellence 2004).



- \* Use every opportunity to encourage the patient to stop smoking (see page 498). This is the only intervention that can prevent the accelerated decline in lung function that occurs in patients with COPD (Fletcher and Peto 1977; Anthonisen 1994). It is essential that patients understand the implications of continuing to smoke and the



- | In patients with moderate or severe COPD (FEV<sub>1</sub> < 50% predicted) inhaled steroids have been shown to reduce the exacerbation rate by 25% (Burge, Calverley, Jones, et al. 2000).

|



such as walking aids, stair lifts, bath aids may be appropriate. Support with domestic care may be needed. A wheelchair and a disabled parking permit may prevent the COPD patient becoming housebound and day-care may provide a break for both the patient and the carer.

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- (c) increased wheeze and shortness of breath;
- (d) increasing confusion or decreasing conscious level;
- (e) condition when stable, especially the need for long-term oxygen;
- (f) severity of previous exacerbations and previous admissions.

The examination. Look for:

- (a)
- 
-

- 
- Adams, N.P., Bestall, J.C., Malouf, R., et al., 2005. Beclomethasone versus placebo for chronic asthma. Cochrane Database Syst. Rev. (1), CD002738. DOI: 10.1002/14651858.CD002738.pub2.
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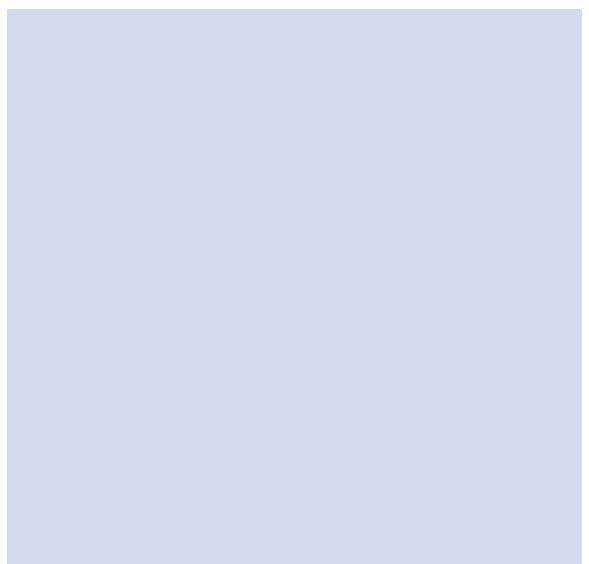
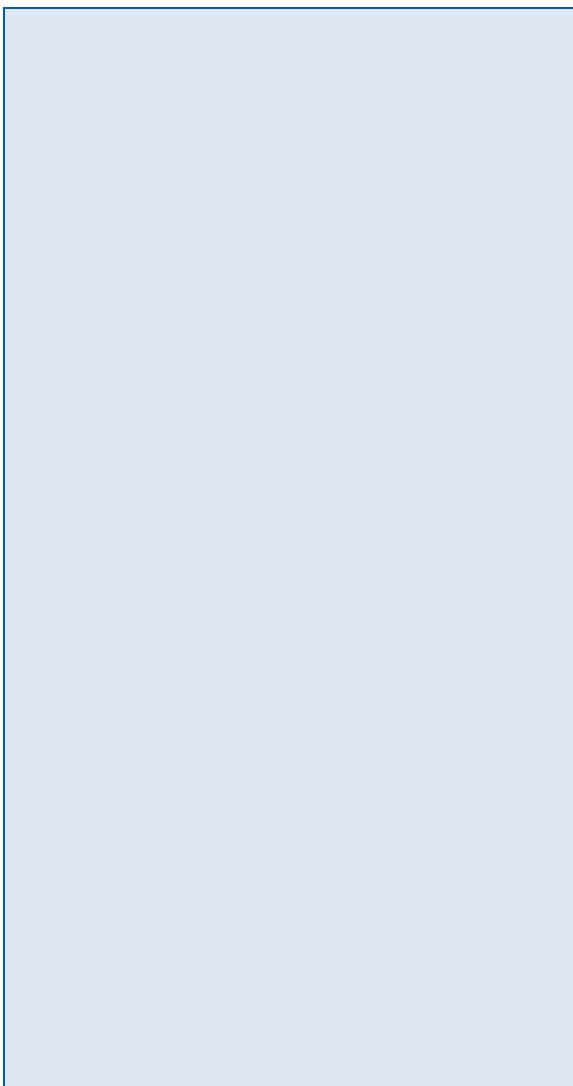
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agents for acute exacerbations of  
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disease. Cochrane Database Syst.  
Rev. (1), CD003900. DOI: 10.1002/  
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Br. J. Gen. Pract. 57, 714–722.
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have a life-threatening condition (Logan and Delaney 2001).

- | Clinical diagnosis without investigation is unreliable (Danish Dyspepsia Study Group 2001); even gastroenterologists are correct in less

 Of any age with:





- | Review whether any change can be made in lifestyle or use of other medications.



- \* Consider use of a COX-2 selective inhibitor or another newer NSAID, which is less toxic to gastric mucosa. The National Institute for Clinical Excellence (NICE) warns that even COX-2 selective inhibitors should be used with caution in patients with a history of peptic ulcer, of GI bleeding or of perforation. NICE's  
~~Recommendation6TDref 36(7in12llenc-306[C1TD11330(sel05222s)¶6{ors)-3306]ould)-330-275Dref329(used)-326(wia~~
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R E D A C T E D

\* Refer patients who do not respond to medical treatment and those with alarm symptoms or signs (Fox and Forgacs 2006):

- GI bleeding;
- iron deficiency anaemia;
- unexplained weight loss;
- dysphagia;
- persistent vomiting;
- epigastric mass.

\*

- | IBS is often associated with symptoms from outside the GI tract: lethargy, backache, headache, dyspareunia and an irritable bladder.

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For details of the diagnosis of constipation see Evidence-based Diagnosis in Primary Care by A. F. Polmear (editor), published by Butterworth-Heinemann, 2008.



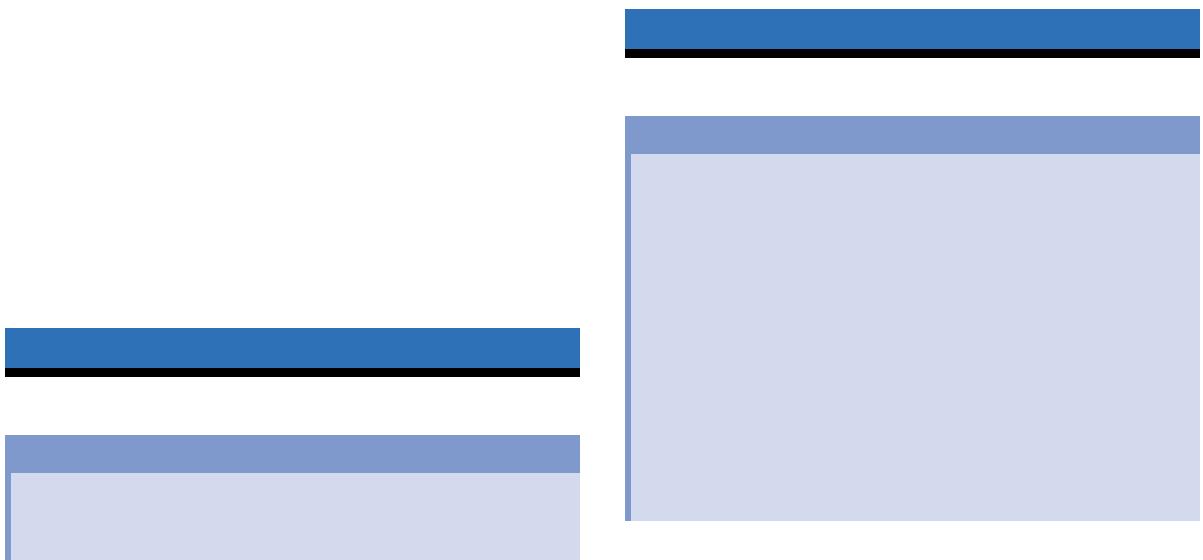
- \* As an alternative, give a single dose of a polyethylene glycol laxative. A small study found this achieved complete success, usually within 24 hours, with no adverse effects (Di Palma, Smith and Cleveland 2002).
- \* Disimpact if necessary.

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- \* Consider colchicine 500 mcg t.d.s. in patients refractory to all other treatment, although it is unlicensed for this use. In a small study of patients resistant to standard medical treatment it increased the number of bowel movements with the only adverse effect an increase in abdominal pain in the first 3 weeks (Verne, Davis, Robinson, et al. 2003).
  - \* Consider referral of patients with intractable constipation for colorectal function studies. Surgery may be helpful in the most severe
- 





\*





with a colorectal surgeon. There is a 25–30% chance of needing a colectomy. A stool frequency of > 8/day or CRP > 45 mg/l at 3 days appears to predict the need for surgery in 85% of cases.

- 
- \* Maintain fluid and carbohydrate intake.

Distal disease:

- \* If disease is confined to the rectum or rectosigmoid give corticosteroids, e.g. Colifoam,
-



- (b) **Diarrhoea** may be controlled by antidiarrhoeals, e.g. codeine phosphate. Diarrhoea caused by free bile acids in patients with ileal resection or dysfunction may be helped by a low-fat diet and colestyramine.

PCSG. 2003. Prevention and Early Detection of Colorectal Cancer in Asymptomatic Patients. Primary Care Society for Gastroenterology. [www.pcsg.org.uk](http://www.pcsg.org.uk)

- \* Refer patients for screening if they have a sufficiently strong family history (see page 218).
- \* Refer patients of any age urgently (to be seen within 2 weeks) (NICE 2005) who have a new occurrence of:

n





- (a) campylobacter: use a macrolide or a quinolone;
- (b) shigella and salmonella: use trimethoprim or a quinolone and then only if there is systemic illness;
- (c) giardia: use metronidazole or tinidazole;
- (d)



patients should still be seen within 2 weeks under Department of Health Guidelines (see Appendix 32). Stop NSAIDs if they are being taken, but do not assume that they were the cause of the blood loss until other pathology has been excluded. Start oral iron once iron deficiency is proved.

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- | Low-dose aspirin doubles the risk of GI bleeding. However, this still leaves major GI bleeding relatively rare with a number needed to harm of 833. That is, 833 patients need to take low-dose aspirin for a year for there to be one patient with a major GI bleed due to aspirin
- (



\*



condition), and that this risk can be reduced by the measures below.

- \* Lifestyle changes. Start the patient on a supervised programme of weight loss, exercise, alcohol cessation and healthy eating, as for the prevention of the development of diabetes.
- \* Assess cardiovascular risk and treat blood



primary care. Am. J.

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- Moayyedi, P., Deeks, J., Talley, N., et al., 2003. An update of the Cochrane Systematic Review of *Helicobacter pylori* eradication therapy in nonulcer dyspepsia: resolving the discrepancy between systematic reviews. *Am. J. Gastroenterol.* 98, 2621–2626.
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haemorrhage: multicentre validation and prospective evaluation. Lancet 373, 42–47.  
Starr, J., 2005.

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2. Give 75 g anhydrous glucose. This can be given as Lucozade 394 ml (using the new 73 kcal/100 ml formulation). It should be drunk over no more than 5 minutes.
  3. Take blood 2 hours later.
- 

- 
- I Studies have shown that it takes, on average, 7–10 years before a patient with type 2 diabetes is diagnosed. At any one time 50% of patients with type 2 diabetes are undiagnosed.
  - I Up to 35% of newly diagnosed patients will have already suffered complications of diabetes (UKPDS 6 1990). It is therefore worthwhile identifying patients earlier as intervention has been shown to reduce the risk of subsequent complications.
  - I The UK National Screening Committee (July 2006) does not support universal screening for diabetes but advises that there might be a benefit from the screening of selected groups. It is still (August 2009) considering how best this might be done.



- White Europeans aged > 40.
- Obesity (BMI > 30) or overweight with a sedentary lifestyle.

■





shown to be effective in reducing the risk of vascular disease in both type 1 (Diabetes Control and Complications Trial Research Group 1993) and type 2 diabetes (UKPDS Group 1998a). However, two recent studies have suggested that intensive blood sugar lowering may not reduce cardiovascular complications and may even increase them (Sherifali 2009). A review of all recent major trials suggests that intensive control is of cardiovascular benefit long-term, but that patients at high cardiovascular risk should achieve glycaemic control gently, not aggressively (Sherifali 2009). Furthermore, ideal levels may not be achievable in some patients. A target should be set for each individual that takes into account age, other illnesses and other risk factors.

- | Type 2 diabetes deteriorates with time. Glycaemic control can usually only be maintained by increasing doses of tablets, sometimes followed by a move to insulin.

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- | Repaglinide and nateglinide are secretagogues which are no more effective than a sulphonylurea but may be useful in sulphonylurea intolerance.
- | Exenatide is recommended by NICE (2009), in addition to metformin and a sulphonylurea for:

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- \* Test annually for:
  - n proteinuria and, if negative, the urinary albumin/creatinine ratio
  - n serum creatinine and calculate the GFR (see page 425).



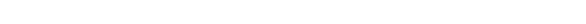
- \* If proteinuria is present check for infection with an MSU and repeat.
- \* If proteinuria persists refer to a diabetologist.



- | Obesity is difficult to influence and indeed patients with type 2 diabetes who have been switched to insulin therapy often improve their glycaemic control whilst at the same time gaining weight. Despite this it is important to encourage patients to exercise and eat a healthy

(g) Check the patient's glucose self-monitoring technique.

(h)

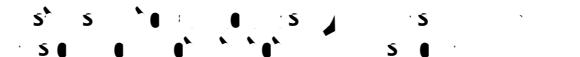




- \* If the patient develops a rash or pruritus change to propylthiouracil propylthiouracil 200–400 mg daily not all patients will be sensitive to both drugs. Again the dosage will subsequently be reduced to a maintenance dose, usually 50–150 mg daily.
- \* Alternatively, give higher doses of antithyroid drugs with levothyroxine sodium: the 'block and replace regimen'. The hope was that this would reduce the incidence of iatrogenic



- \* Warn all patients that they will not feel the benefits of treatment immediately. After 3 months they should notice the difference, but complete recovery can take up to a year.



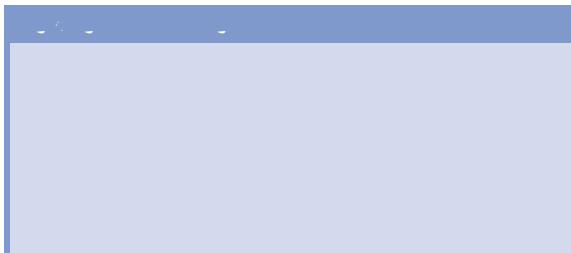
1. Start levothyroxine sodium 25 mcg daily.
2. Increase by 25 mcg each month until 100 mcg a day is reached. Most patients are controlled by 100–150 mcg. Children need more, and old people often less.
3. 6 weeks later: check TFTs. Aim for an FT





becoming seriously ill and there is likely to be any delay in obtaining medical help.

- \* Addisonian crisis. Patients who become ill with an Addisonian crisis should be given 100 mg hydrocortisone i.v. and referred urgently to hospital.





suggestive: 1/3 women in the UK have polycystic ovaries on scan and, of them, only 1/3 have PCOS. A positive scan in a woman with no other evidence of PCOS is likely to be a false positive.

- \* Menstrual irregularities. Consider checking prolactin and TSH, in addition to the above.

- 
- \* Advise on cosmetic methods: shaving, bleaching agents, depilatory creams, plucking.

\*

|



acetate, flutamide, ketoconazole and spironolactone.

- \* Check the size of the testicles and the development of secondary sexual characteristics. Congenital causes, e.g. Klinefelter's syndrome, may only be detected in adult life.
  - \* Order a bone density scan.
  - \*
-

and/or acne (Cochrane Review).

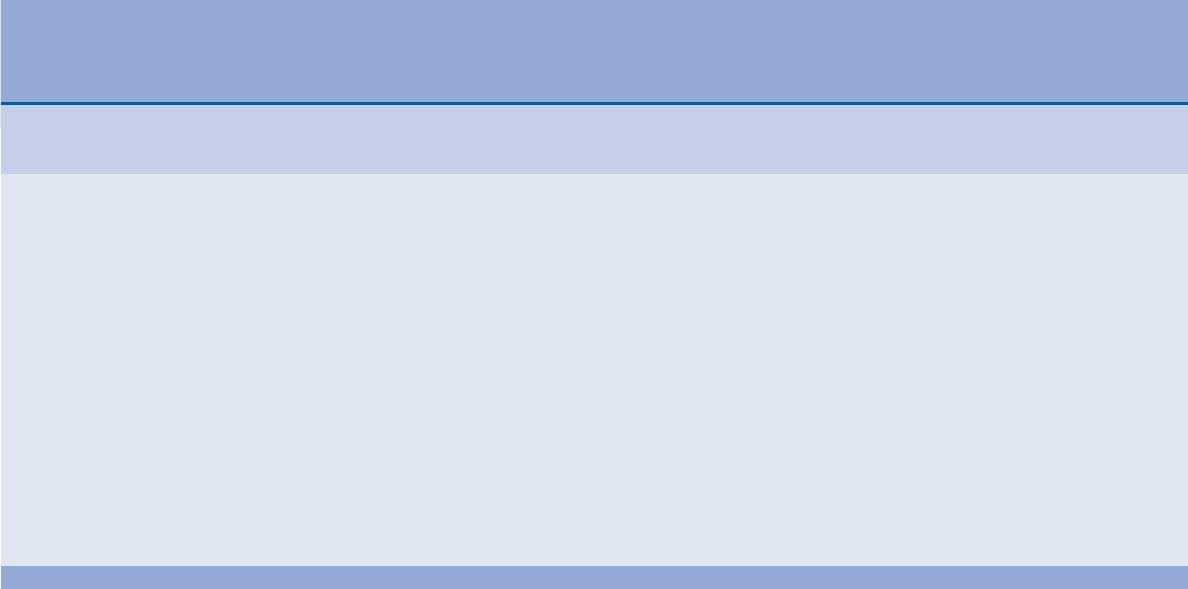
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Care 20, 614–620.
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treatment of erectile dysfunction  
in men with diabetes. JAMA 281,  
421–426.

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Plain X-rays are not routinely indicated. They cannot confirm the diagnosis because degenerative changes in several joints, e.g. spine and knees, start

- | Identify early the small minority with serious pathology needing immediate or urgent attention.
- | Prevent acute back pain becoming chronic.



At presentation:



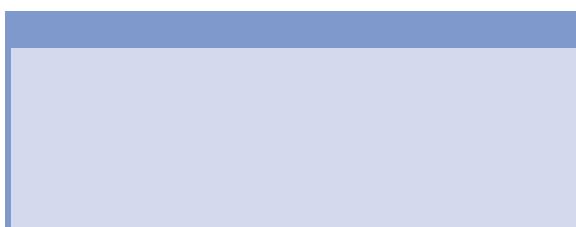
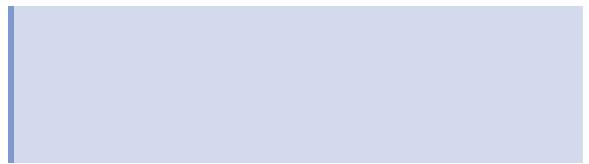


shows evidence of modest benefit at 3 and 12 months from manipulation (UK BEAM Trial Team 2004). This held whether the manipulation was in NHS or private facilities. Conversely, it is now clear that, even in sciatica, epidural corticosteroid injection offers no long-term benefit, although there may be transient benefit at 3 weeks (Arden, Price, Reading, et al. 2005).

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\* Be prepared (





- (a) If pain and movement are both improved refer for physiotherapy.
  - (b) If pain is improved but not movement refer urgently to an upper limb specialist (fracture clinic) as suspected rotator cuff tear. Repair,
- 
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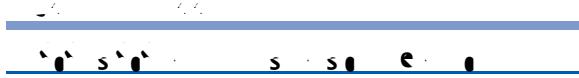
recovered within 1 year. Refer for a brace if the pain is troublesome enough to warrant it.

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- \* Refer to the next fracture clinic if pain and effusion have persisted for > 2 weeks.
  - \* If no grounds for immediate referral, arrange an x-ray. Request AP, lateral and skyline views.
- 



- (c) the patient is unable to weight bear both at injury and when seen.

A foot X-ray is required if there is pain in the midfoot zone and:

(a)

1. Sit with the affected foot crossed over the other knee.
2. Grasp the toes and pull towards the shin until the plantar fascia is stretched.
3. Hold each stretch for a count of 10 and repeat 10 times, three times a day, for 8 weeks.

Characteristics: an insidious onset leading to chronic posterior heel pain and swelling. The pain is worse with activity and pressure from shoes. There may be swelling medially and laterally to the insertion of the Achilles tendon.



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- | Of the traditional NSAIDs, low dose ibuprofen (1.2 g daily) has the lowest gastrointestinal toxicity.
  - | Coxibs increase the risk of thrombotic events
-





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- \* For patients at increased risk of GI complications: follow advice under NSAID
- 



Indications for drug prophylaxis:

(a)





specific (> 95%) for rheumatoid at all stages of the disease. This means that a positive finding makes the diagnosis almost certain. However, the sensitivity is not sufficiently high in early disease (45–60%) to rule out disease so, if it is negative, referral should still be made on clinical grounds.

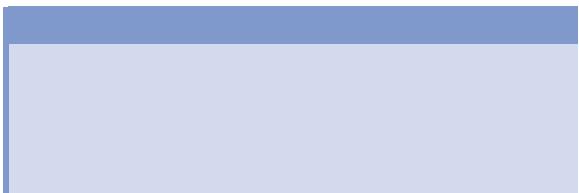
- FBC, because the anaemia of chronic disease is common and to get a baseline because some DMARDs and biologicals affect the blood count.
- LFTs – some DMARDs and biologicals affect the liver.
- U&Es and dip testing of urine because some DMARDs and biologicals affect renal function.

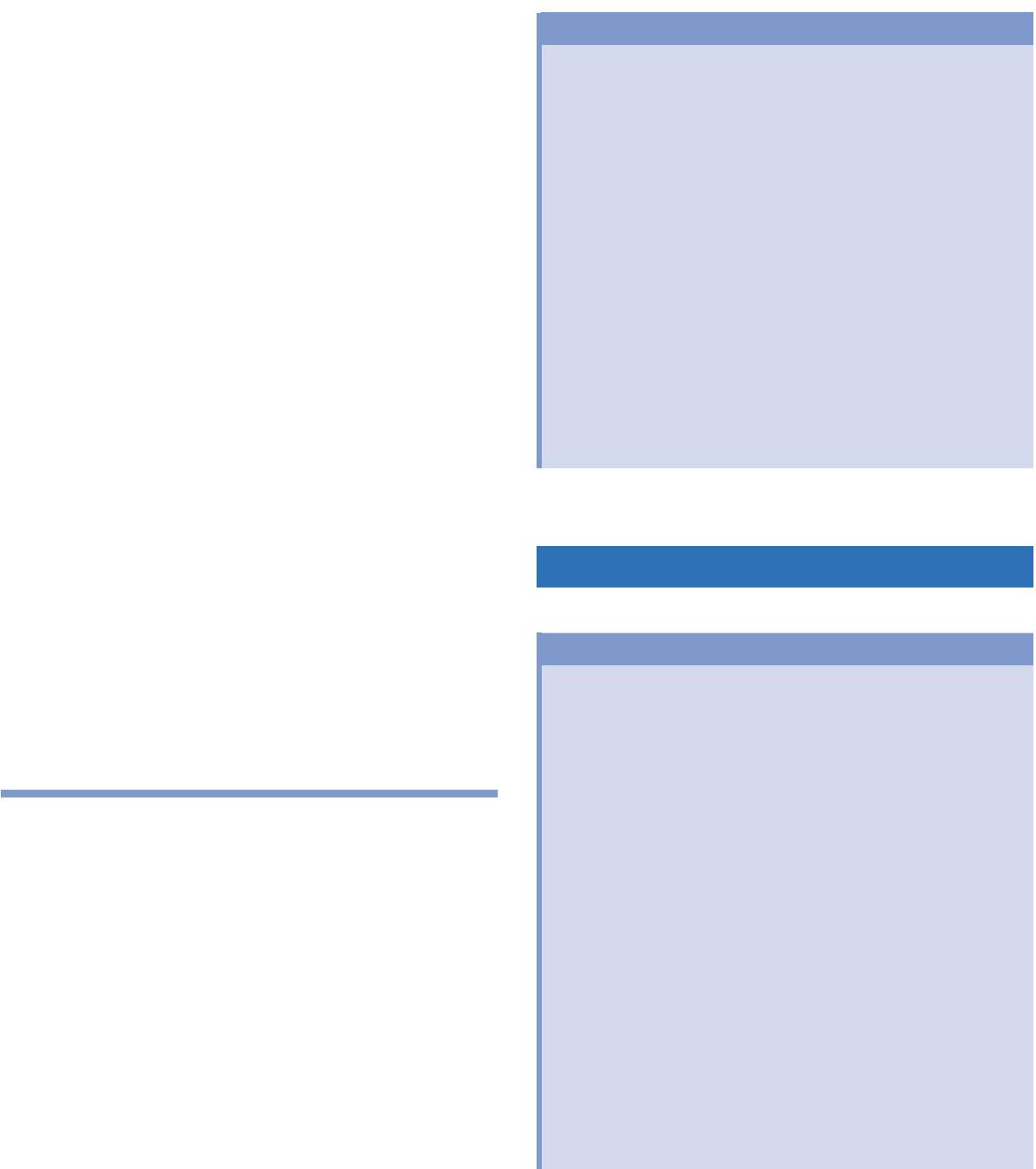
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osteoporotic fracture, <http://www.sheffield.ac.uk/FRAX/index.htm>. The tool will place the patient in one of three bands: low, intermediate or high risk.

- \* If the risk is intermediate, arrange for a DXA scan because the results may alter management. Recalculate the risk using the FRAX tool and the result of the DXA. The tool will now place the patient in one of two bands: low or high risk.
- \* Low risk. Give general advice (see below).
- \* High risk. Offer pharmacological interw4.2c(c291350yo4ill)-334.2c04iongh



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Database Syst. Rev. www.  
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Gross, A., Hoving, J., Haines, T.,  
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disorders. Cochrane Database  
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National Institute for Health and  
Clinical Excellence (NICE), 2008b.  
Adalimumab, Etanercept and  
Infliximab for Ankylosing  
Spondylitis. London: Technology

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no better than placebo in any one patient (i.e. the NNT is at least 2).

- | Guidelines, including the BASH guideline above, usually recommend some form of stepped care, starting with simple analgesics and only moving up if they fail. A large
- 



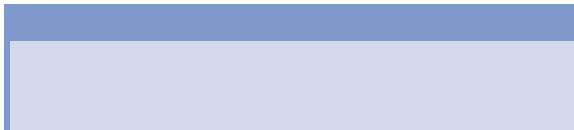


benefit exist for relaxation therapy, stress reduction, biofeedback, chiropractic, and acupuncture. Acupuncture has been shown to reduce the number of attacks with a 15% reduction in medication used, a 25% reduction in visits to the GP and a 15% reduction in days lost to work (

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- (c) Methysergide still has a role where all other prophylaxis has failed, but it should be given under specialist supervision for 4 months at a time with 1 month between courses to reduce the risk of retroperitoneal fibrosis.
- (d) Feverfew 200 mg daily. Despite five trials, a Cochrane review found the evidence mixed and unconvincing (





joint dysfunction, sinus pain or eye muscle disorders.

- \* Explain that the condition is real and benign and that treatment aims at reducing the frequency and severity of symptoms rather than cure.
- \* Explore the tensions in the patient's life.
- \* Advise relaxation techniques: yoga, massage, 'time out' from a stressful day or more formal stress management (Holroyd, O'Donnell, Stensland, et al. 2001).
- \* Assess whether depression is present.

\*



\* Refer urgently if the first attack is sufficiently



not be referred is a child aged 18 months to 5 years who has recovered promptly from a febrile convulsion.

- | The NICE guideline recommends that referral without drug treatment should be the norm. Discuss with the specialist the need to start an antiepileptic drug before the patient has been seen if there has been a previous fit in the preceding 12 months or if the waiting list is longer than 4 weeks. Patients with a congenital neurological deficit are also candidates for drugs at this stage (Scottish Intercollegiate Guidelines Network 2003) as is a patient who does not wish to take the chance of another seizure before the neurological assessment.
- | Once the diagnosis of epilepsy has been made and a decision taken about drug treatment, the role of the GP depends on who else is in the team. An epilepsy nurse specialist may be best suited to act as key worker but the GP is best placed to see the epilepsy in the context of the patient's other medical needs, and will be the only professional in the community available

National Society for Epilepsy, Chesham Lane, Chalfont St Peter, Bucks SL9 ORJ, helpline 01494 601400 for details of local groups and also as an excellent source of information. [www.epilepsynse.org.uk](http://www.epilepsynse.org.uk)

The Joint Epilepsy Council website has links to all the UK and Irish patient organizations: <http://www.jointepilepsycouncil.org.uk>





precipitate phenytoin toxicity, while vigabatrin can lower phenytoin concentrations. These interactions are complex and unpredictable (see BNF section 4.8.1 Control of epilepsy).

(a)



$\mathbf{R}_n = \mathbf{R}_n(\mathbf{C}_n)$



## **Key issues**

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The diagnosis of Parkinson's disease has huge medical, psychological and social implications for the patient and family. The key worker, who may be a



- | NICE recommends that the choice of medication is for the specialist and that the new patient be referred untreated.
  - | No drugs have been shown to be truly neuroprotective. However, dopamine agonists, MAO-B inhibitors and COMT inhibitors are 'levodopa-sparing'; that is, they delay the need to start levodopa itself, or they allow it to be given at a lower dose, thus enabling the patient to use levodopa with benefit until later on in the
-



the parkinsonism. Clozapine is least likely to

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- Hypotensives. Hypotension is an adverse effect of the disease.
  - Baclofen may cause agitation and confusion.
  - Pyroxidine can antagonize the action of levodopa.
- 



2

National Collaborating Centre for Chronic Conditions.  
2008. Stroke: National Clinical Guideline for Diagnosis  
and Initial Management of Acute Stroke and Transient  
Ischaemic Attack (TIA). NICE guideline. Royal College  
of Physicians, London

Intercollegiate Working Party on Stroke. 2004.  
National Clinical Guidelines for Stroke, 2nd edition

## **Stroke checklist**

Paramedics are taught to look for:

- a new asymmetry of the mouth;
  - a new inability to hold one arm out for 5 seconds compared to the other arm;
  -
- 
- 
-



- \* Arrange relief admissions and other support for the carers (e.g. attendance allowance) in consultation with the stroke team.

Prevention should be targeted towards patients with one or more of these factors.

\*

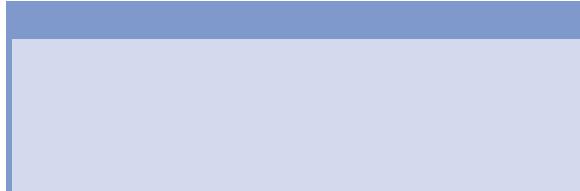
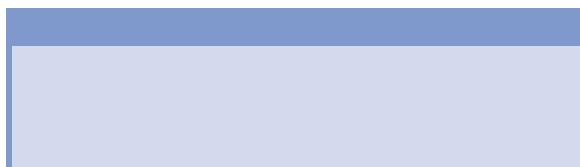
- (a) transient cerebral symptoms caused by hypoperfusion due to cardiac disease;
  - (b) cerebral tumour. Patients with sensory TIAs, jerking TIAs, loss of consciousness or speech arrest should be assumed to have a tumour until proved otherwise;
  - (c) epilepsy. A careful history of the attacks from an observer is important;
  - (d) migraine;
  - (e) traumatic brain injury;
  - (f) subdural haematoma;
  - (g) subarachnoid haemorrhage.
- \* Note that a patient with a TIA that seems to be in the vertebro-basilar distribution, as
- 

[stroke.org.uk](http://stroke.org.uk). It offers posters and leaflets explaining the FAST (Face Arm Speech Test)

Local Stroke Clubs can be accessed through the community rehabilitation team



- \* Respiratory failure. Consider referral for ventilatory support if the quality of life is otherwise sufficiently good. Be prepared to ease



Evidence for glatiramer is less compelling (DTB 2001). Both drugs must be given by injection. NICE determined in 2002 that the drugs should not be prescribed at NHS expense in the UK (NICE 2002). However, the UK Department of



- \* Depression and anxiety. A major depressive episode occurs in > 50% at some stage. Search for it and treat it as actively as in a patient without MS.
  - \* Emotionalism. Consider a trial of an antidepressant (a TCA or SSRI).
  - \* Dysphagia. If the patient has bulbar signs (dysarthria, ataxia, or abnormal eye movements), or if there has been a chest infection, assess swallowing formally.
  - \* Dysarthria. If communication is affected refer to a speech and language therapist.
  - \* Pain may be neuropathic or musculoskeletal. The former needs a trial of carbamazepine, gabapentin, or amitriptyline, see page 677; the latter needs physiotherapy and analgesics.
  - \* Visual problems that are not corrected with glasses need assessment by an ophthalmologist. Optic neuritis is the commonest cause of visual loss.
  - \* Cognitive impairment, if suspected, should be formally assessed and the results used to inform the management of every aspect of the patient's care.
  - \* Bladder problems: see below.
  - \* Constipation. Can usually be managed with adequate fluid, bulk laxatives and stool softeners. More severe constipation may require osmotic agents, bowel stimulants, anal stimulation, suppositories, or enemas. Bedridden patients may develop faecal impaction unresponsive to these measures and require manual disimpaction. Faecal incontinence may be minimized by adherence to a schedule for bowel movements and by early detection of impaction.
  - \* Sexual problems. The precise a
-

While MS is not often fatal in itself, life is shortened by an average of 6-11 years and it may complicate a death from another condition. See Motor



- \* Raise the question of an advance directive (see page 22). It can be a great help if the patient decides certain key issues, and records the





Anon., 2000. Sodium valproate for migraine prevention. Bandolier Nov. Available on [www.jr2.ox.ac.uk/bandolier/booth/migraine/valpr.html](http://www.jr2.ox.ac.uk/bandolier/booth/migraine/valpr.html).

Anon., 2001. More evidence on



- Leonardi-Bee, J., Bath, P.,  
Bousser, M.-G., et al., 2005.  
Dipyridamole for preventing  
recurrent ischemic stroke and  
other vascular events: a meta-  
analysis of individual patient data  
from randomized controlled trials.  
*Stroke* 36, 162–168.
- Linn, F.H.H., Wijdicks, E.F.M.,  
van der Graaf, Y., et al., 1994.  
Prospective study of sentinel  
headache in aneurysmal  
subarachnoid haemorrhage.  
*Lancet* 344, 590–593.
- Lipton, R., Stewart, W., Stone, A.,

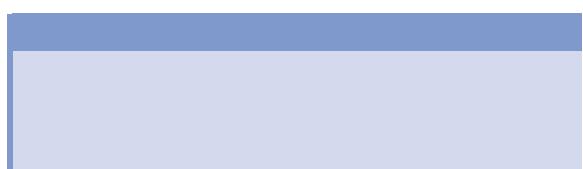
The Cochrane Library, Issue 3.  
John Wiley, Chichester, UK.  
PROGRESS Collaborative Group,  
2001. Randomised trial of a  
perindopril-based blood-pressure-  
lowering regimen among 6105  
individuals with previous stroke  
or transient ischaemic attack.  
*Lancet* 358, 1033–1041.  
Rascol, O., Goetz, C., Koller, W., et al.,  
2002. Treatment interventions for

Wiart, L., Petit, H., Joseph, P., et al.,  
2000. Fluoxetine in early post-  
stroke depression: a double-blind  
placebo-controlled study. *Stroke*





(c)

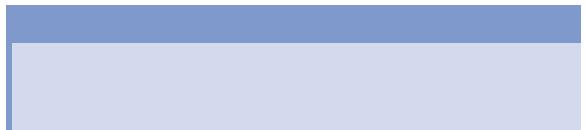
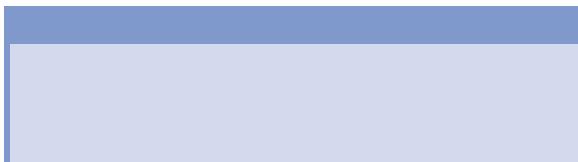


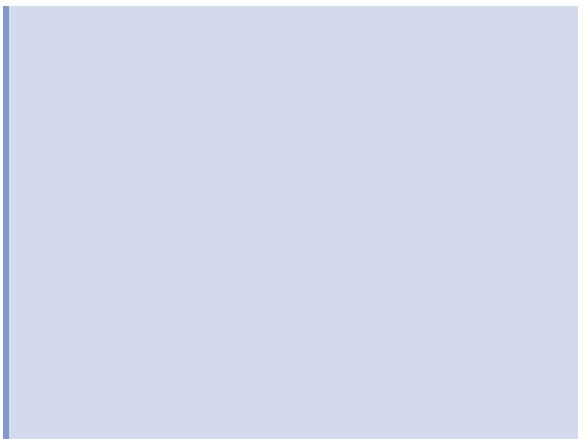


**1** **2** **3** **4** **5** **6** **7** **8**



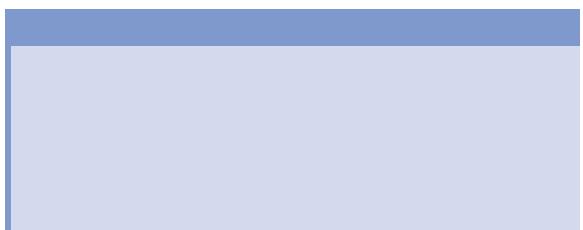
- \* Exclude pregnancy.
- \* Check whether irregular periods or amenorrhoea have always been a feature. They





Consider the diagnosis if two of the following three criteria are met:

- (a) Polycystic ovaries on USS (either 12 or more follicles in at least one ovary or increased ovarian volume (

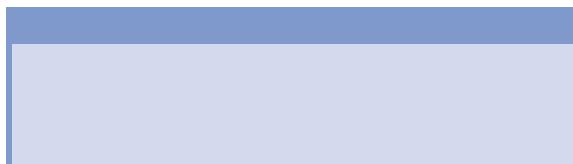
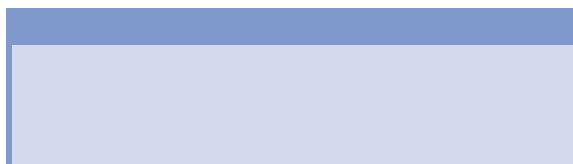




- | PID is usually the result of ascending infection from the endocervix. *Neisseria gonorrhoeae* and *Chlamydia trachomatis* have been identified

(c) to trace, investigate and treat the woman's partner(s) if an STD is diagnosed (Robinson and Kell 1995). One study of women with acute salpingitis found that 30 out of 34 male contacts had urethritis (Kinghorn, Duerden and Hafiz 1986). Another study found that 60% of contacts had relevant infections, and that in most of these it was asymptomatic (Kamwendo, Johansson, Moi, et al. 1993). Consider referral to a GUM clinic for contact tracing;

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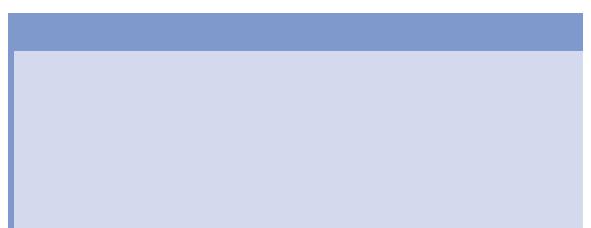
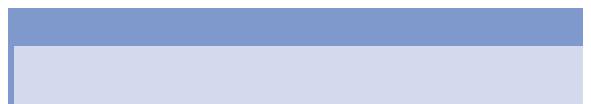


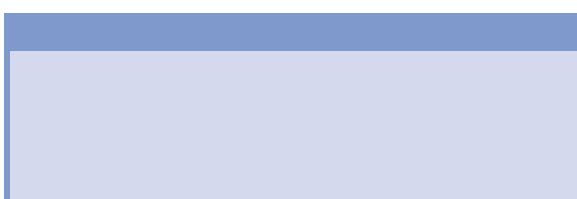
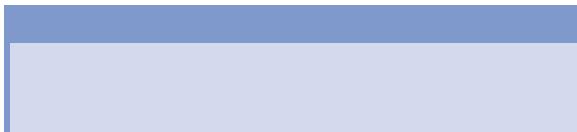
information from poor quality trials, but the evidence suggests that B<sub>6</sub>

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that of premenopausal women and the risk increases with age. In women on HRT this risk is further increased with a hazard ratio of 2.1 (95%CI 1.39 to 3.25) (Rossouw, Anderson, Prentice, et al. 2002). The highest risk occurs in the first 6 months to a year of use. This means that, in women aged 50–60 HRT will cause an extra four cases for every 1000 women using HRT for 5 years. The risk may be less in women using a patch than in those on oral HRT (RCOG 2004).

| Dementia



Absolute contraindications include:

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- (a) acute-phase myocardial infarction, pulmonary embolism or deep vein thrombosis (DVT);
- (b) active endometrial or breast cancer;
- (c) pregnancy;
- (d) undiagnosed breast mass;
- (e) uninvestigated abnormal vaginal bleeding;
- (f) severe active liver disease.

Note: Many contraindications given in prescribing data sheets are derived from high-dose combined oral contraceptives, and are, in the view of most experts,

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and so do not produce a withdrawal bleed,  
although irregular bleeding can occur in the

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- (b) changing the oestrogen type (swap between the two main forms of oestrogen: oestradiol
- 
- 
-

- | Perimenopausal women cannot be assumed to be infertile.
- | Routine HRT preparations do not suppress ovulation and are not contraceptive.

\*

- | Smears cannot be interpreted (inadequate) if the specimen is obscured by inflammatory cells/blood, does not contain the right type of cells or is incorrectly labelled.
- \* Repeat an inadequate smear after between 6 weeks and 3 months. Repeating the smear within 6 weeks does not allow adequate tissue re-growth. Refer if there are two further inadequate smears,







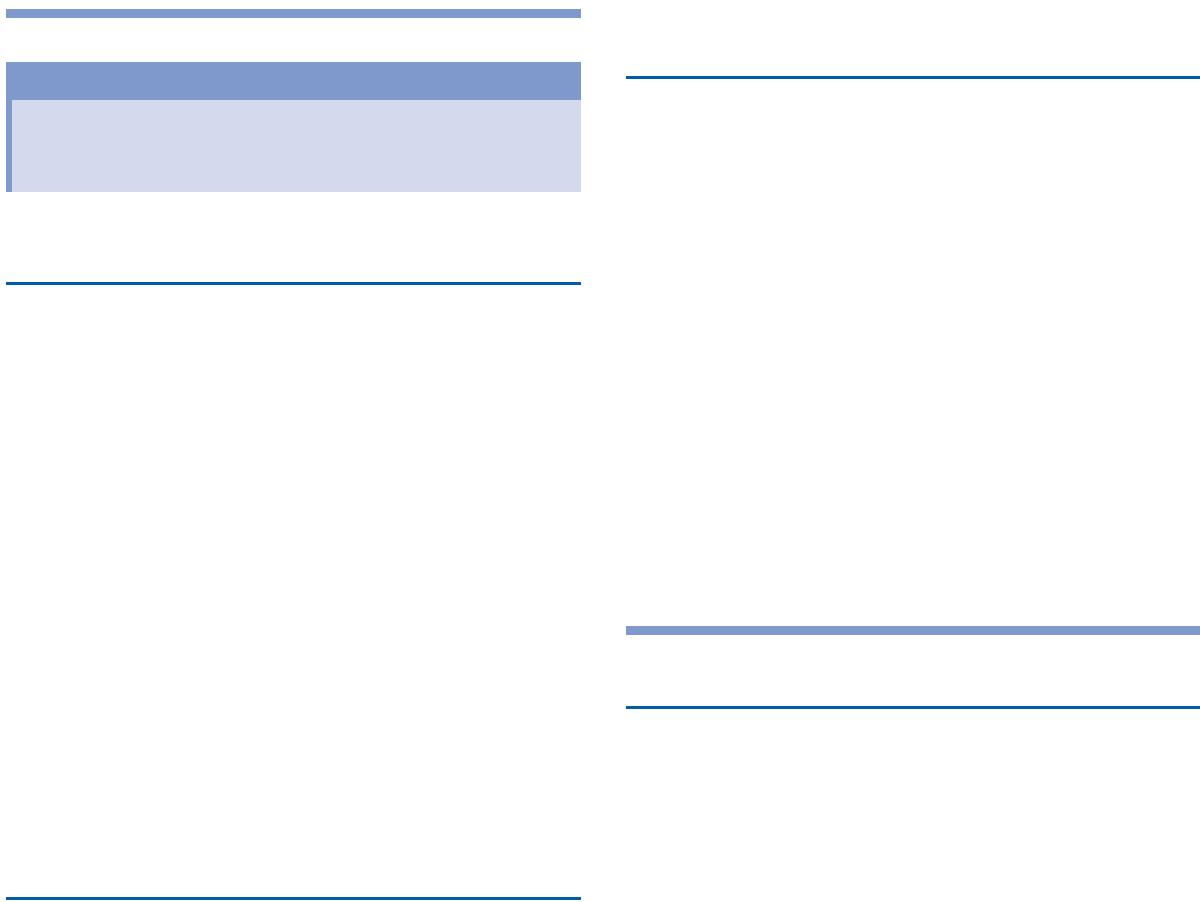




(n) Diabetes



Their risk of VTE is 3.1 times the risk they would run with a levonorgestrel or norethisterone preparation (Kemmeren, Algra and Grobbee 2001). These brands may be useful, however, for those who have side-effects, for acne sufferers or those with cycle control problems.



reasonably certain she is not pregnant  
(Table 12.2). There is no need to wait for the  
next period.

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- (f) Cancer. Overall, the balance of risks and benefits of the COC on cancer is beneficial.
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after a 2-day course and elimination of PFIs  
during this time (



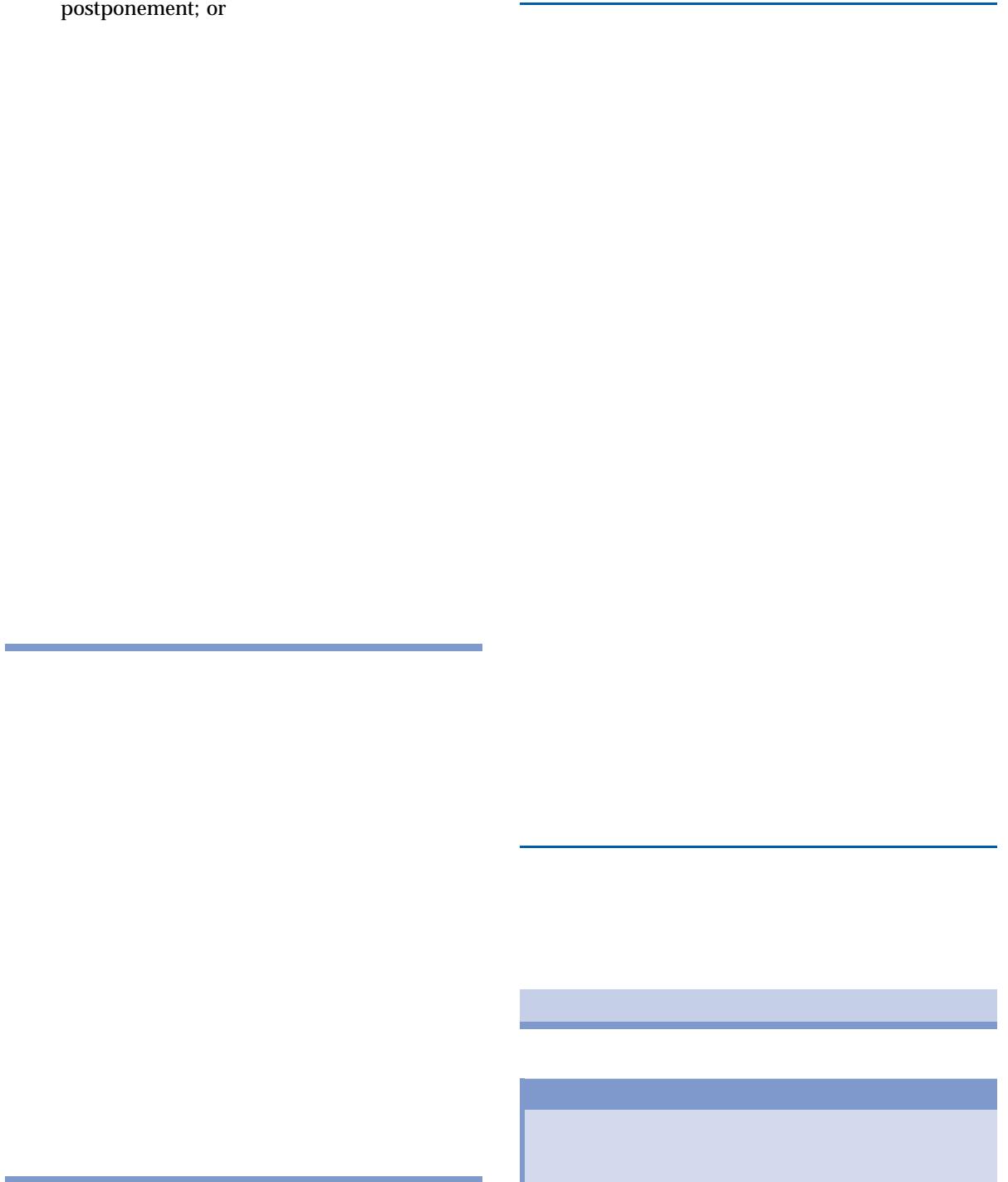
(Logynon, Triadene) or 14 (Binovum) days' postponement; or

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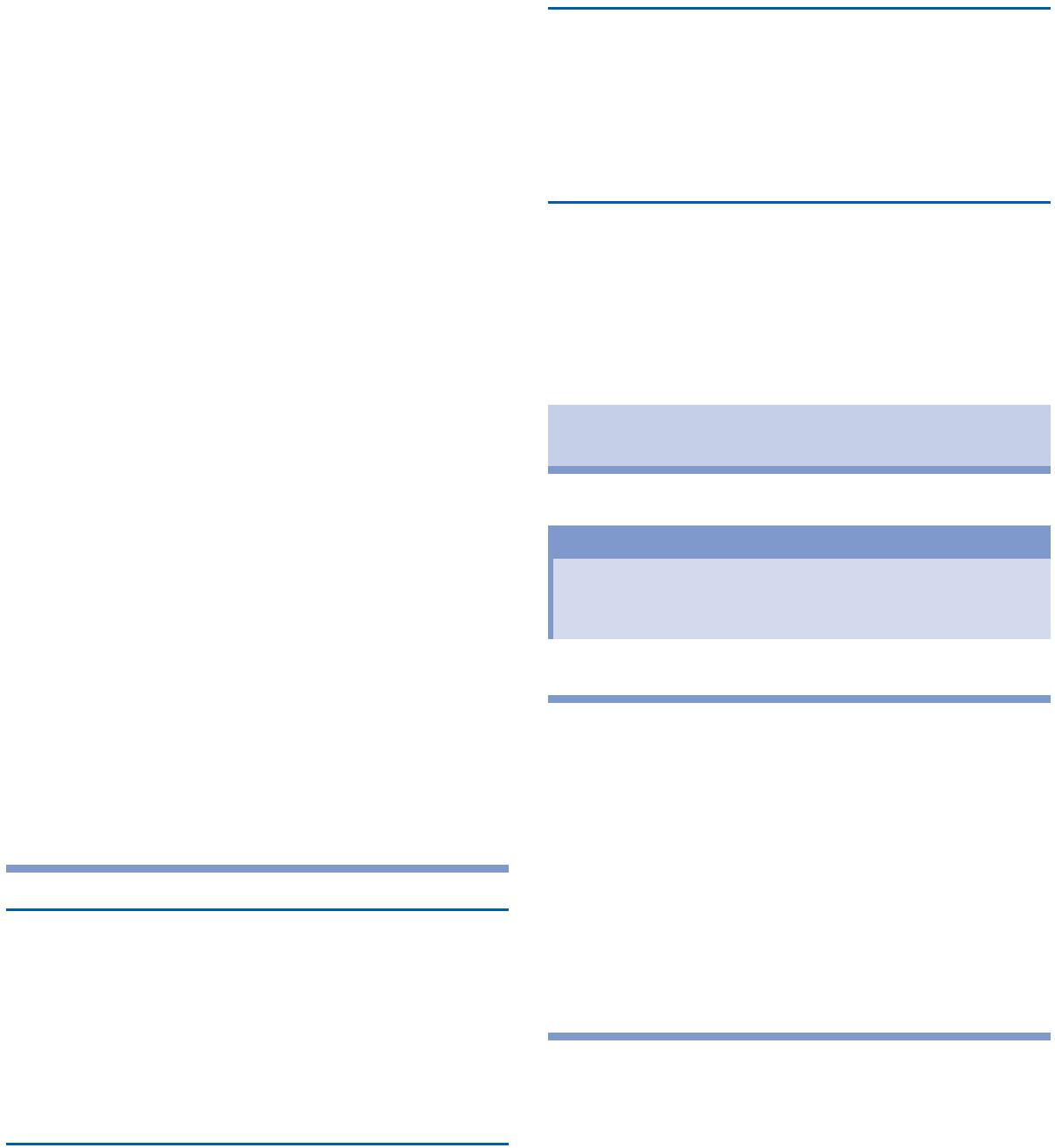
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(c)









(a) Breast cancer – current.



- (a) Ischaemic heart disease – current or past history.
- (b) Stroke – history of CVA, if occurred when using implant.
- (c) Unexplained vaginal bleeding – before evaluation.
- (d) Breast cancer – past history and no evidence of current disease for 5 years.
- (e) Cirrhosis – severe (decompensated).
- (f) Liver tumours benign (hepatocellular adenoma) or malignant (hepatoma).
- (g) SLE



- \* If there are symptoms and the IUD is present, remove it and treat with antibiotics.
- \* Actinomyces-like organisms (ALOs) may be found on a cervical smear.
  - (a) If the patient is asymptomatic, leave the IUD in place;
  - (b) If the patient has symptoms, i.e. pain or discharge, remove the IUD and investigate the patient for pelvic pain/STIs, treat with antibiotics as appropriate and consider referral to GUM or gynaecology.









- \* Discuss the risks of contracting STIs, especially chlamydia, and how condoms protect against transmission.
  - \* Raise the advantages, both psychological and physical, of not having sex at a young age.
- 

- 
- \* Warn the patient that BTB can occur in the first few packets, is not harmful, and to come in and discuss the problem rather than stop the pill.
  - \* Stress the value of using the condom as well to reduce the risk of STIs including HIV (dual protection). Young people should be shown how to use condoms.
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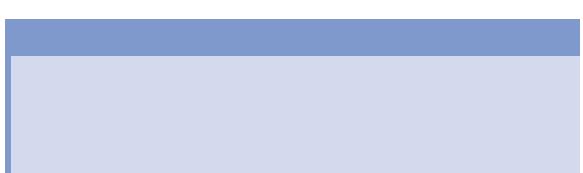
- (b) Patients should be made aware of the high efficacy of alternative long-acting reversible contraceptive methods (National Collaborating Centre for Women's and Children's Health 2005).
- (c) The possibility of death of partner or child should be covered.
- (d) The possibility of relationship breakdown should be discussed.
- (e) The pros and cons of male versus female sterilization should be explained.





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(d) pelvic causes with tenderness on rocking the cervix or palpating the fornices, e.g. endometriosis, pelvic infection, ovarian pathology;

(e)

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- Sexual & Reproductive  
Healthcare, London.
- Clinical Effectiveness Unit, 2008b.  
Progestogen-only Injectable  
Contraception. Faculty of Sexual  
& Reproductive Healthcare,  
London.
- Clinical Effectiveness Unit, 2008c.  
Progestogen-only Implants.  
Faculty of Sexual & Reproductive  
Healthcare, London.
- Clinical Effectiveness Unit, 2009a. UK  
medical eligibility criteria. Faculty  
of Sexual and Reproductive  
Healthcare, London.
- Clinical Effectiveness Unit, 2009b.  
Postnatal sexual and reproductive  
health. Faculty of Sexual and  
Reproductive Healthcare, London.
- Clinical Effectiveness Unit, 2009c.  
Sexual and reproductive health for  
individuals with inflammatoryyondon.



- cyproterone or levonorgestrel contraceptives. Lancet 358, 1427–1429.
- Vessey, M., Painter, R., 2006. Oral contraceptive use and cancer. Findings in a large cohort study, 1968–2004. Br. J. Cancer 95, 385–389.
- von Hertzen, H., Piaggio, G., Ding, J., et al., 2002. Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomised controlled trial (WHO-RCT) (ISRCTN36037913). Lancet 358, 1421–1427.



- | Whilst prepregnancy counselling offers an opportunity to reinforce good health habits and identify potential problems for pregnancy early, there is no evidence from randomized controlled trials that women who attend such visits have better health or pregnancy outcomes.



(d) Family history or previous infant with neural tube defects:

All women in this category should receive folic acid prior to conception. Give 5 mg daily, starting 1 month prior to stopping contraception, and continue throughout the first trimester.

Women should also receive advice about antenatal diagnosis (see below).

A decision should be taken about the need to stop other drugs which are associated with fetal abnormalities, e.g. warfarin and lithium. The NICE guideline Antenatal and postnatal mental health: clinical management and service guidance, available on [www.nice.org.uk](http://www.nice.org.uk), discusses the risks associated with



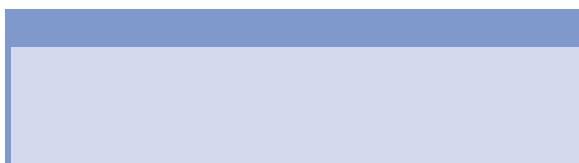








\* Prescribe an H



- \* If there is modest loss, minor pain and the os is
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- 
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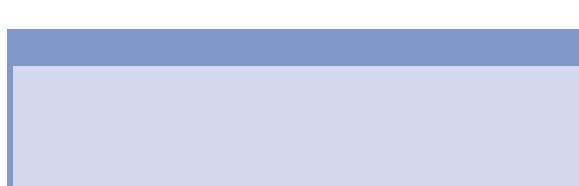
unlikely to be fruitful unless three or more pregnancies have miscarried (see page 381). Having three consecutive miscarriages gives a patient a subsequent risk of 40%. Referral for investigation is then traditional, but earlier referral may be justified as discussed above.

The Miscarriage Association, c/o Clayton Hospital,  
Northgate, Wakefield, West Yorkshire, WF1 3JS, helpline  
01924 200799, administration 01924 200795 for leaflets  
about all aspects of miscarriage, ectopic pregnancy and  
molar pregnancy.

that she is immune and that there is little need to worry.

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- I Zidovudine can reduce the chance of vertical transmission if given to the mother antenatally and during labour, and to the baby postpartum

(



(c) What is your weight? Are you gaining weight appropriately?

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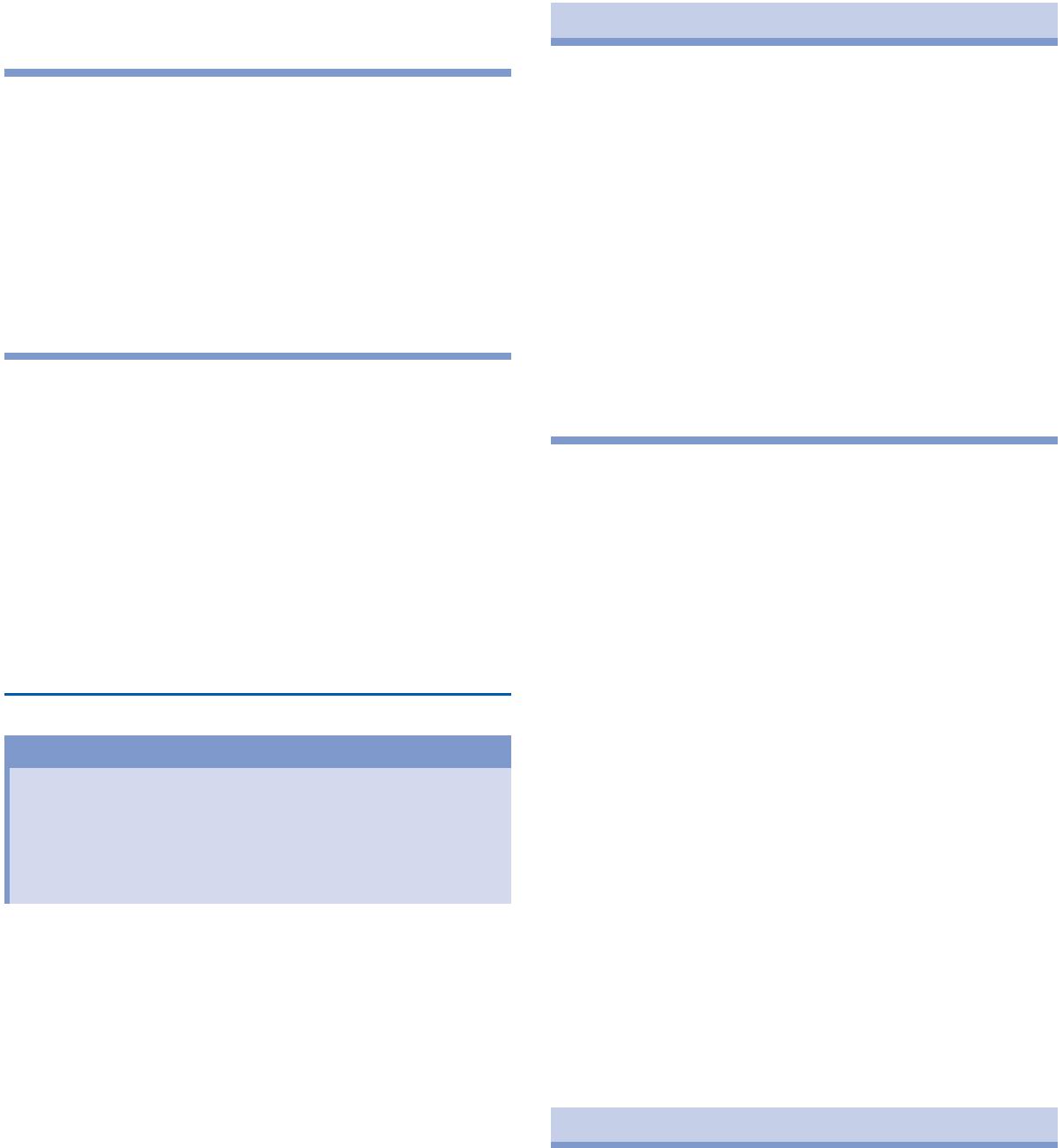
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| 24 hour-urinary protein





higher risk of neural tube defects women with diabetes should take 5 mg (instead of 400 mcg) of folate daily before conception until the end of the 12th week. The GP should emphasize the importance of good control throughout pregnancy, even if the majority of the management will be done by the hospital.

\*

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enzyme-inducing drugs, i.e. phenytoin, barbiturates and carbamazepine.

- \* Reassure women that the majority have a



- \* Opiates: arrange an urgent outpatient appointment. Maintain the patient on oral methadone meanwhile.
- 

Royal College of GPs and the BMA. 1997.

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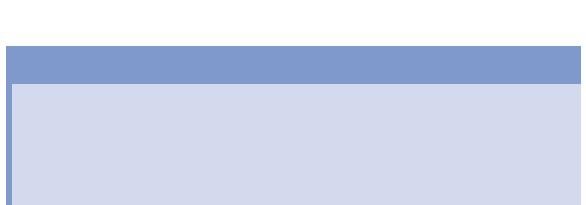
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- \* Registration. Encourage early registration of the baby with the registrar; the start of Child Allowance is dependent on this. Register the baby with the practice.

Review the patient's experiences.

- \* Does she have any outstanding questions about what happened during labour or birth?
- \* Is she getting enough sleep? Who is sharing in

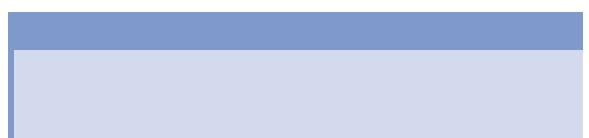


- \* Allow breast milk to dry on the nipple when not feeding, or, if the skin is broken, use white soft paraffin.
- 
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- 
- \* Endometritis. Patients with fever, pain and foul-smelling lochia are likely to need admission, but early cases could be treated at home with amoxicillin/erythromycin and metronidazole (see page 402).

\*

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- (a) admit if the baby is unwell or is at risk because of prematurity, small for dates or birth asphyxia;
  - (b) otherwise, arrange for a serum bilirubin. If
-

DTB, 1995. The practical management  
of thyroid disease in pregnancy.

Drug Ther. Bull. 33, 75–77.

Everett, C., 1997. Incidence and

- Milkiewicz, P., Elias, E.,  
Williamson, C., et al., 2002.  
Obstetric cholestasis. BMJ 324,  
123–124.
- Miller, A., Barr, R., Eaton, W.O., 1993.  
Crying and motor behaviour of  
six-week-old infants and  
postpartum maternal mood.  
Paediatrics 92 (4), 551–558.
- Milne, F., Redman, C., Walker, J.,  
et al., 2005. Pre-eclampsia





SIGN. 2006. Clinical Guideline 88: Management of Suspected Bacterial Urinary Tract Infection in Adults. <http://www.sign.ac.uk/guidelines/fulltext/88/index.html>



- | Half of women who present with frequency and





- \* Ask the patient to keep a diary of input, output and symptoms for 1 week, and consider managing as for detrusor instability (see Urge incontinence, below).
- 
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- \* If culture positive: treat with doxycycline 200 mg o.d. or ciprofloxacin 500 mg b.d. for up to 12 weeks or until symptoms have completely settled, whichever is the longer, and only then





- **s**

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- \* Dip the urine for sugar and evidence of infection. Consider an MSU.

\*

volume of urine passed does not suggest that the patient is drinking too much;

- (c) practise holding the urine when the urge to pass it is there; and
- (d) slowly increase the interval between voiding up to 2–3 hours.





However, note that men with lower urinary tract symptoms are no more likely than others to have prostate cancer and there is an argument that a digital rectal examination (and PSA testing) are not routinely indicated with lower urinary tract symptoms (see the Wilt and N'Dow 2008 BMJ reviews above).

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### **s** **s**

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- \* Perform a dipstick urinalysis.

- \*





should not be offered to an asymptomatic man over 75 years old with < 10 years life expectancy.

---

- (b) Family history. A family history of cancers of the prostate, breast, ovary, bladder and kidney increase the risk.
  - (c) Race. African Americans have a rate that is double that of whites. Asian and Oriental men
- 
-



alkaline, or taken after exercise, during a fever, during menstruation, or in the presence of vaginal or urethral discharge. False negatives occur in dilute



these are not present and repeat dipstick is still positive, believe the dipstick. Red cells may have lysed on the journey to the laboratory.

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## **National Kidney Foundation-K/DOQI Clinical Practice Guidelines**

National Kidney Foundation-K/DOQI. 2002. Clinical





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- Abrams, P., 1995. Managing lower urinary tract symptoms in older men. *BMJ* 310, 1113–1117.
- Akbari, A., Swedko, P.J., Clark, H.D., et al., 2004. Detection of chronic kidney disease with laboratory reporting of estimated glomerular filtration rate and an educational program. *Arch. Int. Med.* 164, 1788–1792.
- Albert, X., Huertas, I., Pereiro, I., et al., 2004. Antibiotics for preventing recurrent urinary tract infection in non-pregnant women (Cochrane Review). In: The Cochrane Library. Issue 4.
- Andrews, S., Brooks, P.T., Hanbury, D.C., 2002. Ultrasonography and abdominal radiography versus intravenous

Emberton, M., Neal, D.E., Black, N.,  
et al., 1996. The effect of  
prostatectomy on symptom

50%  
R 0.00  
C 0.00

Orthopaedic problems in primary care

427  
Head and neck injN6io

- (l) Previous cranial neurosurgery.
- (m) Suspicion of non-accidental injury.
- (n) Any other cause for concern.

NICE recommends that the GP use discretion in



If the patient is not admitted, warn the patient's attendant, verbally and in writing, to report:

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- (a) unusual drowsiness;
- (b) severe headache;
- (c) vomiting;
- (d) visual disturbance or deafness;
- (e) strange behaviour;
- (f) anything else worrying.

- \* Record the warning in the patient's notes.
  - \* Give paracetamol or codeine for headache, but nothing stronger.
- 
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$\gamma_{z_1} \gamma_{z_2} \gamma_{z_3} \gamma_{z_4}$

\*







Vitak, Chen, et al. 2001). Five-year survival in those in whom cancer is found is almost 75% and 10-year mortality is reduced by 25–30% (Blanks, Moss, McGahan, et al. 2000).

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may decide to take oral contraception as





For details of the diagnosis of intermittent claudica-









RECORDED

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- \* Request FBC, LFTs and U&Es – many hospitals can provide results within 24 hours if notified.
- \* Request an abdominal USS as an outpatient to confirm the diagnosis – refer to the surgeons for cholecystectomy if gallstones are confirmed.

\*



burns are white or charred, and are also

- \* Decide on the need to refer to the emergency department. This is advised in:
  - (a) penetrating wounds, in which nerves, tendons or other tissues could be injured.  
This includes the skull in infants with bites to the head;
  - (b)



- n evidence of any infection in a hand wound.
- n evidence of serious cellulitis in a wound over



care for depressive illness can be deployed with success for such cases.

- | Pain: postoperative pain syndromes are protean. Often there is no clear explanation for the pain. The symptoms are very real for the patient and require a sympathetic approach to achieve control (see page 676). Referral to the local pain clinic is advised if there is no identifiable reason for the pain and simple measures for controlling the pain have not succeeded.
- 

- \* Cellulitis. Use an antibiotic which covers streptococci and staphylococci, e.g. erythromycin or co-amoxiclav.
  - \* Abscess. Incise or refer immediately.
  - \* Serous ooze
- 
- 
-

- (f) iritis which was not present on discharge;  
(g) postoperative conjunctivitis not settling after  
10 days of antibiotic/steroid topically.



- 
- Acheson, A., Scholefield, J., 2008.  
Management of haemorrhoids.  
BMJ 336, 380–383.
- Ahimastos, A., Lawler, A., Reid, C.,  
et al., 2006. Brief communication:  
ramipril markedly improves

- Greenhalgh, R., Powell, J., 2007.  
Screening for aortic aneurysm.  
*BMJ* 335, 732–733.
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Brooks, D., et al., 1994. Effects of  
case management after severe  
head injury. *BMJ* 308, 1199–1205.
- Haslam, R., 1996. Head injuries.  
Nelson Textbook of Pediatrics,

Excellence, London. Available  
on [www.nice.org.uk](http://www.nice.org.uk).

NICE, 2009. Venous  
thromboembolism: reducing the  
risk of venous thromboembolism  
in patients admitted to hospital.  
NICE Clinical Guideline. 1st draft  
March 2009. Available:







- (f) there has been a poor response to an appropriate antidepressant in maximum dosage, with good compliance, taken for an adequate period of time;
  - (g) there is social isolation, little family support,
- 



6 months after recovery. Anyone with a recent previous episode of major depression should take it for 2 years, as should other people at high risk of relapse, e.g. the elderly (see below).

- \* Prescribe a generic preparation. There is some evidence that venlafaxine is more effective than other antidepressants (Smith, Dempster, Glanville, et al. 2002) but adverse effects may also be greater (Cipriani, Geddes and Barbui 2007). A recent study suggests that the risk-benefit profile from 117 RCTs favours sertraline (Cipriani, Furukawa, Salanti, et al. 2009).
- \* Drug dosage
  - (a)

- 
- \* Check that the patient was taking the drug correctly. An apparent relapse could be due to a discontinuation reaction in a patient who has omitted one or more doses.
  - \* Where there is evidence that an increased dose may be associated with an improved response, and there are no adverse effects, consider increasing the dose gradually, waiting for 4 weeks each time before deciding that the



SIGN. Postnatal Depression and Puerperal Psychosis.  
Scottish Intercollegiate Guidelines Network 2002.  
Available: [www.sign.ac.uk](http://www.sign.ac.uk)

- | Postnatal depression occurs in 10–15% of women in the first year after delivery, usually in the first 6 months. The symptoms are almost always present at 6 weeks. It is distinct from the transient ‘blues’ of the first 10 days, and from a puerperal psychosis which is likely to need admission.
-





## Clinical History

- \* Identify underlying precipitating events and the steps taken by the patient to modify or cope



12 months if the PTSD has lasted more than 3 months, to avoid relapse. There is an impression that patients do better if the drugs are started early in the course of the condition. NICE recommends paroxetine and mirtazapine for general use and other antidepressants for use by mental health specialists (NICE 2005b).

- \* Other drugs. Consider a beta-blocker for a patient disabled by startle and hyperarousal symptoms. The evidence for benzodiazepines is poor.

dependence, tolerance and difficulties on withdrawal. Use a short-acting benzodiazepine. The National Institute for Clinical Excellence has assessed the 'Z drugs' (zaleplon, zolpidem and zopiclone), and found insufficient evidence to recommend them over the cheaper benzodiazepines (NICE 2004b).

\*





- \* Assess the patient's disability. How does it affect family relationships, sex, work, and physical and mental state? Is a job at risk? Is alcohol or caffeine intake excessive?
- \* Explain the options:
  - (a) Cognitive behavioural therapy (CBT). CBT has the strongest evidence of benefit (Gale and Oakley-Browne 2004b). A 1–2 hour weekly session will be needed for a total of 8–20 hours with a trained professional. Briefly, it involves training the patient to act and think differently from their usual manner until a new response to life becomes natural to them. However, do not 'oversell' it to the patient. Even in randomized controlled trials only half have recovered at 6-month follow-up (Fisher and Durham 1999). Those who do show some response continue to improve for at least 2 years after treatment has ended (Dugas, Ladouceur and Leger 2003). Anxiety management, without cognitive



and feeling anxious) are common to both.  
Sometime the patient is clear that the symptoms  
feel different from the original anxiety. If in



- n Check your watch. What seems like an hour may only be 5 minutes.

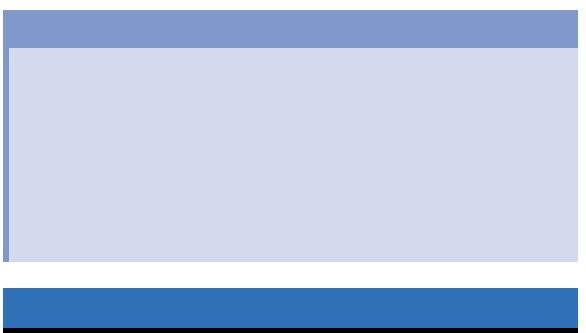




- | Fear of flying. Exposure therapy, either using a computer stimulation, or just sitting in an







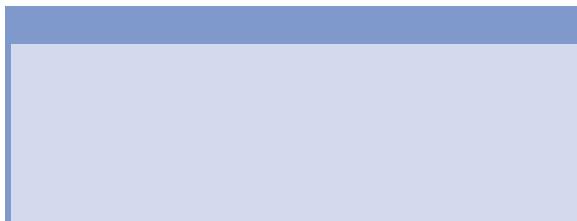
- disorganized or strange speech;
  - agitation or bizarre behaviour;
  - extreme and labile emotional states;
  - family concern about recent changes in personality, behaviour or function.
- 

- \* Obtain a careful history from family or friends of recent events and changes in the patient's behaviour.
  - \* Ask about drug or alcohol misuse.
  - \* Assess the mental state including the risk of suicide and of harm to others.
  - \* Make a differential diagnosis if this is a first
- 
-

- \* Try to ensure that a relative or friend is present.
- \* Tell someone in the practice whom you are visiting and when.
- \* Arrange for the practice staff to phone you after a specified time.

\*

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Section 3 allows for detention for 6 months. It is occasionally used in the community instead of Section 4 if the patient is already known to the psychiatric services. In practice it is almost always used once the patient is in hospital and before a section 2 or 4 has expired.

Section 7 allows the appointment of a guardian for up to 6 months. The guardian has the power to insist that the patient live at a specified place, attend for work, training, or medical appointments.

Section 136 allows the





- antipsychotics are likely to be extrapyramidal; with atypical antipsychotics they are likely to be weight gain and hyperprolactinaemia;
- existence of drug or alcohol problems;
  - whether the patient has been admitted in the past 6 months;
  - patients on clozapine need monitoring for agranulocytosis, weekly for 6 months then monthly in the UK. Organizing this is the responsibility of the prescriber. If delegated to primary care a written protocol is needed.

## Clinical practice

### Conventional antipsychotics

- Extra-pyramidal adverse effects. If they occur, discuss management with the specialist. The main options are:
  - (a)





## **Treatment**

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- \* Discuss the options with the patient's specialist.  
They are likely to involve:
    - (a) an oral antipsychotic or valproic acid or carbamazepine. Olanzapine is probably more effective than the other options but at the expense of greater sedation and weight gain (Macritchie, Geddes, Scott, et al. 2003);
    - (b) increasing lithium while keeping the blood level within the therapeutic range;
- 
- 
- 





restriction: meta-analysis. BMJ  
332, 385–388.

Buszewicz, M., Pistrang, N.,  
Barker, C., et al., 2006. Patients  
experiences of GP consultations

- Gloaguen, V., Cottraux, J., Cucherat, M., et al., 1998. A meta-analysis of the effects of cognitive therapy in depressed patients. *J. Affect. Disord.* 49, 59–72.
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- Goldberg, D., Lecrubier, Y., 1995. Form and frequency of mental disorders across centres. In: Ustun, B., Sartorius, N. (eds.), *Mental illness in general health care: an international study*. WHO, John Wiley, Chichester, pp. 323–334.
- Goodwin, G., 2003. Evidence-based guidelines for treating bipolar disorder: recommendations from the British Association for Psychopharmacology. *J. Psychopharmacol.* 17, 149–173.
- Haddad, P., Lejoyeux, M., Young, A., 1998. Antidepressant

NICE, 2004a. Depression:

practice: is using criteria for  
diagnosis as a routine the answer?

Br. J. Gen. Pract. 50, 284–287.

Walsh, J., Muehlbach, M., Lauter, S.,



- | In 2009, the Department of Health (England and Wales) advised:
  - (a) limits of up to 3-4 units per day for men and 2-3 for women;
  - (b) a daily tally rather than a weekly one;
  - (c) that these maximum sensible limits should not be drunk every day (Department of Health, Home Office, Department for Education and Skills, Department for Culture Media and Sport 2007).

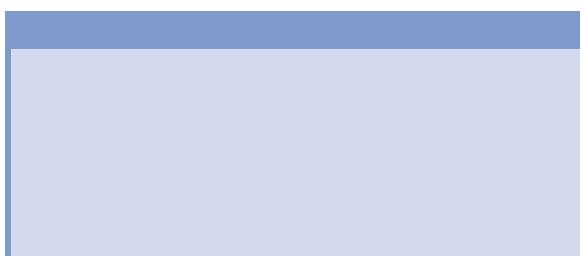
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specialist care or individual or group counsellng that they can provide.

- \* Involve family, friends and organizations to provide support. Family members who enrol in Al-Anon facilitation therapy can succeed in getting previously unmotivated drinkers into





- \* Offer withdrawal with explanation to all patients on long-term benzodiazepines who
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- 



Department of Health (England) and the devolved administrations. 2007. Drug Misuse and Dependence: UK Guidelines on Clinical Management



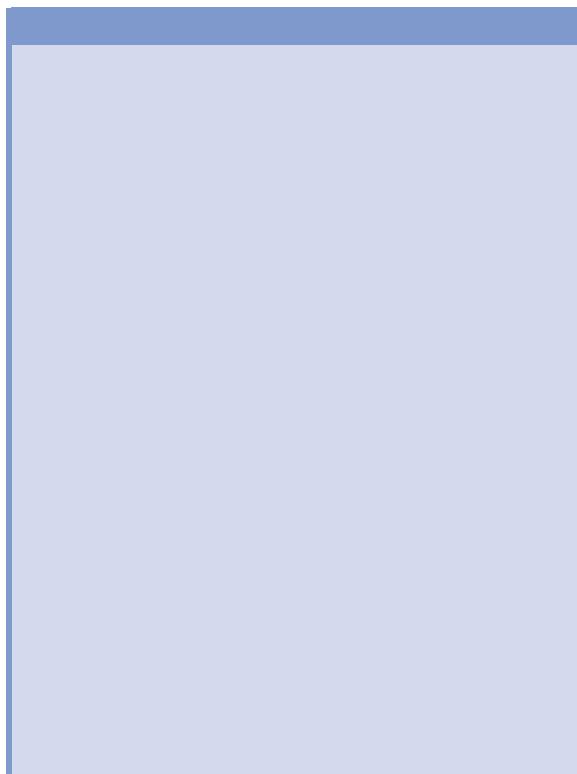
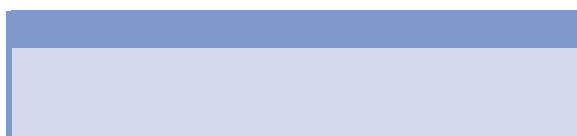
- \* Safe sex. Check that the user is using condoms. Drug users are a high-risk group for HIV and may acquire it sexually.
  - \* Specialist help. Encourage the patient to attend the local substance misuse clinic.
  - \* Admission. Arrange urgent admission for th
-







- \* Explain that withdrawal symptoms are likely to be mild and short-lived: insomnia, sweating, anxiety, restlessness, lethargy, anorexia, nausea, tremor and paranoia.
- \* Agree a goal along the line of the approach taken with problem drinkers and arrange to see









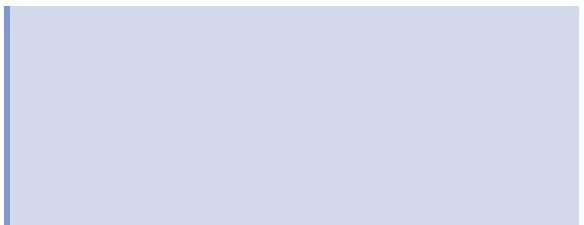
1998; Hughes 1989; Blondal, Gudmundsson and Olafsdottir 1999).

- | NRT appears to be safe when given to smokers with cardiovascular disease (Benowitz and Gourlay 1997).



|





dependence: National Institute on  
Drug Abuse Collaborative  
Cocaine Treatment Study. Arch.  
Gen. Psychiatry 56, 493–502.  
Cummings, K., Hyland, A.,  
Ockene, J., 1997. Use of the  
nicotine skin patch by smokers in  
20 communities in the US. Tob.  
Control 6 (Suppl. 2), S63–S70.  
Dean, A., Whyte, I., 2004. Emergency





Obesity 503

[REDACTED]

- (a) overweight  $\geq$  BMI of  $\geq 23 \text{ kg/m}^2$ ;
- (b) obese  $\geq 27.5 \text{ kg/m}^2$ ;
- (c)



being evaluated and at present, there is  
insufficient evidence to make

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daily meals. They can be effective in short-term weight loss (

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As this book was being prepared for publication the other drug licensed for the treatment of obesity in the UK, sibutramine, was suspended from sale. This followed an interim analysis of the SCOUT study (the Sibutramine Cardiovascular OUTcomes study). High risk patients, who were overweight and who had either cardiovascular disease or type 2 diabetes, were given sibutramine for 5 years. The analysis revealed a 16% increase in cardiovascular adverse events, mainly non-fatal stroke and myocardial infarction, compared to placebo







Have you recently lost more than



National Institute for Clinical Excellence. 2004. Eating Disorders. NICE Clinical Guideline No. 9. Available: [www.nice.org.uk](http://www.nice.org.uk) (search on 'Eating disorders')

Treasure J, Schmidt U. 2005. Anorexia nervosa. Clinical Evidence. Issue 12. BMJ Publishing Group, London

Prognosis. In anorexia nervosa 43% recover, while, of those admitted to hospital, 10% die.

Work up: pulse, blood pressure, FBC, U&Es, TFTs.

\* Severe anorexia. Admit if there is evidence of severe anorexia:

(a)  $\text{BMI} < 15 \text{ kg/m}^2$  especially if there has been





National Institute of Clinical Excellence, 2004. Eating Disorders; Quick Reference Guide. NICE.  
Available: [www.nice.org](http://www.nice.org).

Nawaz, H., Katz, D.L., 2001. American College of Preventative Medicine Practice Policy Statement. Weight management counselling of overweight adults. Am. J. Prev. Med. 21, 73–78.

NHLBI, 1998. Executive summary of the clinical guidelines on the identification, evaluation and treatment of overweight and obesity in adults. Arch. Intern. Med. 158, 1855–1867.

References 518





## Treatment

- Antidepressants. Evidence that they improve fatigue is poor but they may improve depression if it is present (Reid, Chalder, Cleare, et al.



- therapy? A UK randomised trial.  
Br. J. Gen. Pract. 51, 19–24.
- Shepherd, C., 2001. Pacing and exercise in chronic fatigue syndrome. *Physiotherapy* 87, 395–396.
- Sugarman, J.R., Berg, A.O., 1984. Evaluation of fatigue in a family practice. *J. Fam. Pract.* 19 (5), 643–647.
- Whiting, P., Bagnall, A.M., Sowden, A., et al., 2001. Interventions for the treatment and management of chronic fatigue syndrome. *JAMA* 286, 1360–1368.

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Refer urgently if there is:

- (a) a sudden severe hearing loss; or
- (b) a sudden onset of dizziness with nystagmus.



This remains largely unsubstantiated.

- \* Encourage breastfeeding.
- \* Feed upright where possible.
- \* Avoid cigarette smoke exposure (Strachan and Cook 1998).



There is some evidence to support antibiotic prophylaxis in children with recurrent otitis media (NNT of 9). The type, duration and criteria for antibiotic use are not clear (O'Neill 2001).

Admit any patient with:

- (a) tenderness, redness or oedema over the mastoid; or
- (b)

' q s o s s ' s o

This is more likely if there is a history of eczema or



- (b) Unilateral deafness with a longer history.  
Referral is less urgent, but the patient may  
have a treatable cause (e.g. acoustic neuroma).

\*



\* Examine the canal and drum.

If wax is present it may be contributing to the deafness, although removal of wax only raises the hearing threshold by at least 10 dB in one third (Memel, Langley, Watkins, et al. 2002):

(a)

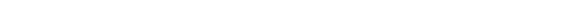
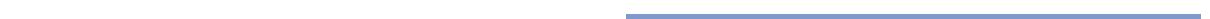


**• s**

- | The majority of grommets are extruded within 9 months, and only need to be reinserted if deafness recurs.
- | Discharge should be treated by aural toilet and antibiotic/corticosteroid drops (see page 525).
- | Swimming and bathing pose no danger, but diving should be banned.

of the labyrinth or central connections. It is present on sudden changes in posture, and is commonly due to benign positional vertigo (see below).

(b)



- This is characterized by vertigo associated with at least one of either hearing loss, tinnitus or a feeling of aural fullness. Symptoms may be unilateral. They vary in severity. In the long term, deafness may remain but the vertigo and tinnitus to a lesser degree. Some people develop a severe bilateral disorder and may need surgery.

|



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Note that the nystagmus may only last a few seconds and will not occur at all in some patients, in whom the diagnosis must be made on the history alone. Note also that the patient will experience vertigo at the same time as the nystagmus.

- \* Explain that the vertigo may last for a few weeks





Do not give for more than half the year (Lund 1990).

- \* Give a 10-day course of a beta-lactamase-resistant antibiotic if symptoms do not resolve with topical steroids. In children with proven sinusitis the benefit is modest (NNT  $\frac{1}{4}$  8)  
(



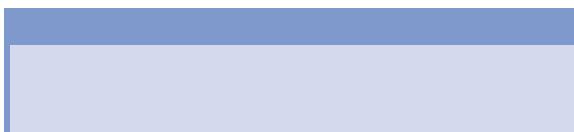
## **Non-pharmacological treatments**

- | Antihistamines reduce the nasal itching, watery hypersecretion and sneezing, but do little for nasal blockage (Pearlman, Lumry, Winder, et al. 1995). Intermittent use may be enough.
- \* Use an antihistamine nasal spray for rapid relief (Ratner, van Bavel, Martin, et al. 1998).

\*

hours. Some patients need indefinite prophylaxis with intranasal mometasone or fluticasone, which have lower bioavailability than betamethasone drops. The evidence for oral steroids comes from a single small trial of poor quality (Patiar and Reece 2009).

- \* The BSACI guidelines (above) recommend that
- 



- \* If the diagnosis is confirmed, the patient should inform the DVLA and insurance company. Driving will only be permitted once a doctor has confirmed that the condition is controlled.

- \* Advise patients to make the following lifestyle changes:
  - (a) lose weight if obese, especially if the neck circumference is > 43 cm (17 inches).
  - (b) avoid alcohol before bed-time;
  - (c)

complications are uncommon. It would be necessary to treat 30 children and 145 adults to prevent one case of acute otitis media (Del Mar, Glasziou and Spinks 2000).

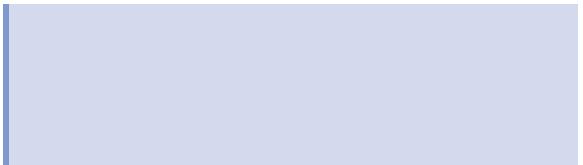
| Antibiotics have no effect on the incidence of URTI, whether bacterial or viral, in the subsequent 6 months. The early use of antibiotics may even increase the chance of recurrence

(El-Daher, Hijazi, Rawashdeh et al. 1991 n c i , t 8 . 5 2 8 2 1 ( n c ) \_1 1 ( - D ) 9 7 0 2 0 0 7 . 9 7 0 2 4 5 . 3 5 4

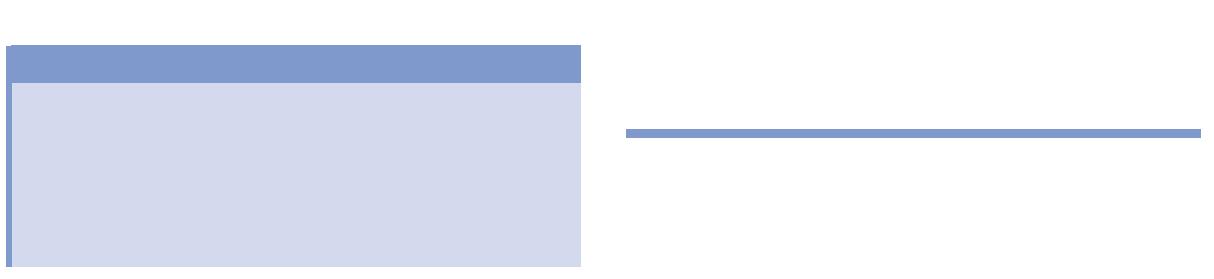
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- \* Patients with a past history of rheumatic fever should already be taking prophylactic penicillin V 250 mg b.d. If they develop a sore throat they should be given a cephalosporin or co-amoxiclav, in case they have beta-lactamase-producing organisms in the pharynx that are destroying the penicillin.
- \* Patients on chemotherapy, immunosuppressive drugs or carbimazole. Check the WBC.
- \* Patients with a past history of quinsy



Chon T, Nguyen L. 2007. What are the best treatments for herpes labialis? J Fam Pract 56, 576–578

- \* First attack: if seen within the first 48 hours give an oral antiviral agent, e.g. aciclovir, unless mild. It can halve the time to healing, at least in children.
  - \* Recurrent attacks:
- 
- 
- 



\*



may be haematological (anaemia; iron deficiency; low serum B<sub>12</sub> and a raised red

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El-Daher, N.T., Hijazi, S.S.,



- randomised controlled trials. BMJ 317, 1624–1629.
- Yardley, L., Beech, S., Zander, L., et al., 1998. A randomised controlled trial of exercise therapy for dizziness and vertigo in primary care. Br. J. Gen. Pract. 48, 1136–1140.
- Young, T., Palta, M., Dempsey, J.,

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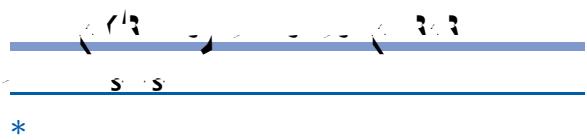
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- \* Refer to an ophthalmologist but less urgently.
- \* Give aspirin 75 mg daily.
- \* Take blood for an ESR. If the clinical picture



- \* In a child, refer as a matter of urgency.  
Any opacity of the ocular media can have a catastrophic effect on the development of vision and should be diagnosed and treated promptly.
- \* In a young adult. Refer but also investigate for diabetes or any other systemic disease that a clinical history might lead you to suspect.
- \* In the elderly:
  - Exclude diabetes.
  - Refer to an optician all patients who have



the secretion of aqueous. They can cause systemic symptoms and may unmask latent and previously undiagnosed heart failure and airway obstruction (Kirwan, Nightingale, Bunce, et al. 2002). Systemic effects can be reduced by finger pressure on the caruncle or by shutting the eyes for several minutes after instilling the drops. This approach may also increase ocular absorption of the drug.

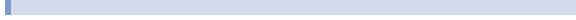
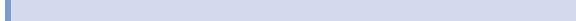
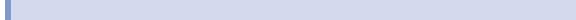
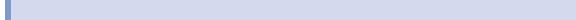
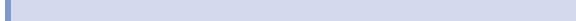
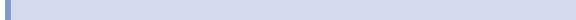
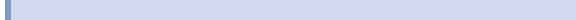
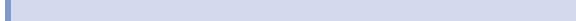
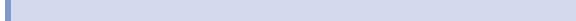
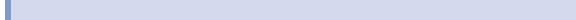
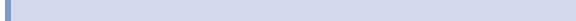
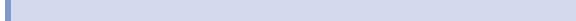
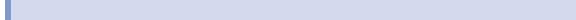
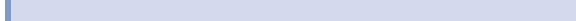
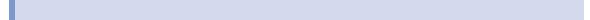
- (c) Carbonic anhydrase inhibitors (dorzolamide, brinzolamide or oral acetazolamide) which reduce the secretion of aqueous. Oral acetazolamide is the most effective but has

| Registration is voluntary and would normally be offered at the time of certification. Registration entitles a person to a range of benefits and concessions, and help from some local voluntary groups. The receipt of a CVI by the social services department entitles that person to have his or her name added to the register. This also acts as a trigger for social services to arrange an assessment of the person's social care needs.

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- 
- Allen, D., Vasavada, A., 2006.  
Cataract and surgery for cataract.  
BMJ 333, 128–132.
- Chong, E.W.T., Wong, T.Y., Kreis, A.  
J., et al., 2007. Dietary antioxidants

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be widespread. It has a predilection for the flexures of the elbows and knees, plus the face

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- | Safety. Hydrocortisone 1% (cream or, preferably, ointment) is safe for all ages and at all sites bar one: the sole exception is the eyelid, where prolonged use may cause glaucoma. Potent preparations should not be prescribed for children, nor for flexures or the face. Their use should be restricted in sites prone to striae; the breasts, abdomen, upper arms and thighs.
- | Rates of absorption vary according to site: scrotal skin absorbs 40 times more than the palm, with the forehead, axilla, and back absorbing six

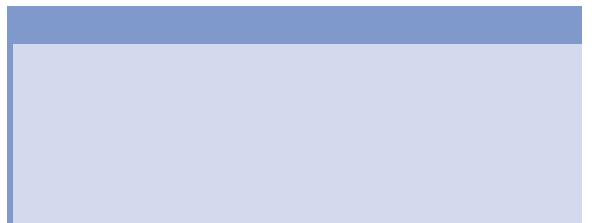
Controlling the house dust mite may improve eczema but the reduction in dust levels must be extreme, with synthetic mattress covers, spraying and high filtration vacuuming (Berth-Jones, Damstra, Golsch, et al. 2003).

Oral corticosteroids can be used as rescue therapy while waiting for an urgent consultant opinion. Patients should not be maintained on steroids or courses of steroids for prolonged periods.

Tacrolimus, a topical immunomodulator, can be used as a steroid sparing agent in moderate to

\* General advice:

(a) Wash hands as infrequently as possible. Use emulsifying ointment not soap but if soap is



- \* Explain that treatment is to prevent new spots, not to get rid of the spots that already there.  
Topical treatment must therefore be applied to
-





- \* Prescribe the following general measures for all patients who want treatment, regardless of what other treatment they are using:
  - (a) a soap substitute, e.g. aqueous cream; and

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- | Genital warts are of greatest concern because they are associated with malignancy, particularly some subtypes with cervical cancer.
  - | Warts will probably always remit spontaneously but the time to remission may be very variable.
- 



Lancaster T, Silagy C, Gray S. 1995. Primary care management of acute herpes zoster: systematic review of evidence from randomized controlled trials. *Br J Gen Pract* 45, 39–45

Yaphe J, Lancaster T. 2001. Postherpetic neuralgia. Clinical Evidence, Issue 5. BMJ Publishing Group, London. Available: [www.clinicalevidence.org](http://www.clinicalevidence.org)

- | The prevention of post-herpetic neuralgia (PHN) and the prompt treatment of ophthalmic zoster (see page 553) are the most important issues. PHN follows shingles in 50% of patients aged over 60 and 75% of patients over 70, of whom half will still be suffering 1 year later (Bandolier 1995).
- | Oral aciclovir (800 mg five times daily for 5 days), famciclovir (250 mg t.d.s. for 7 days), and valaciclovir (1 g t.d.s for 7 days) taken within 72 hours of the appearance of the rash

patients, diabetics, patients with leucocytosis or vascular insufficiency (Musette, Benichou, Noblesse, et al.





[REDACTED]

[REDACTED]

[REDACTED]

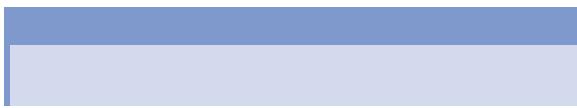
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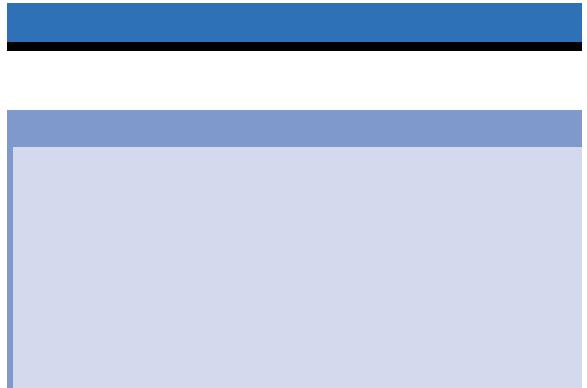




Is there a medical contraindication?

- \* Check that the ABI is not below 0.8.
- \* Check that there is not marked oedema. The pressure of a stocking may cause tissue damage. Control the oedema by medical means or compression bandages first.
- \* Check that the patient does not have a condition which is associated with small vessel disease: diabetes or rheumatoid arthritis. Compression may close off these already compromised small arteries.

\*



- \* Oral corticosteroids can shorten an episode of acute urticaria. Give prednisolone 50 mg/day for 3 days but not long term.
  - \* Refer patients whose chronic urticaria is sufficiently troublesome. Even their prognosis is not bad; referred patients have a 50% chance
-



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Accurate diagnosis and good long-term management are therefore crucial in maintaining quality of life and minimizing anxiety (Munoz-Furlong 2003).

- | Evidence-based guidelines for the diagnosis and management of allergies are available (Chapman, Bernstein, Lee, et al. 2006). Note that data from randomized controlled trials are limited in the area of food allergies; these guidelines are based on a systematic review of the best available evidence.
-



Allergy UK. 3 White Oak Square, London Road, Swanley, Kent, BR8 7AG. Helpline: 01322 619898; fax 01322 470330; email: info@allergyuk.org; website: www.allergyuk.org

The Informall Database A searchable database with information on allergenic foods for professionals and lay people; website:  
[foodallergens.ifr.ac.uk/](http://foodallergens.ifr.ac.uk/)

---



Simons and Choo 2009). Guidelines are based on the best available evidence.

---

- | Anaphylaxis can have a significant long-term impact on a patient's everyday life beyond the immediate ill-effects of a reaction. Managing an unfamiliar set of risks may be challenging for patients, particularly immediately after diagnosis. The possibility of further reactions can lead to increased anxiety. Allergen avoidance requires careful vigilance, and may adversely affect the patient's family and social life. Good long-term management is therefore essential in maintaining quality of life (Panesar, Walker and Sheikh 2003; Akeson, Worth and Sheikh 2007; Avery, King, Knight and Hourihane 2003; o5dl.l5nu.-d5.l1els/T1\_0fld
- 
-

9. Following treatment, the patient should be





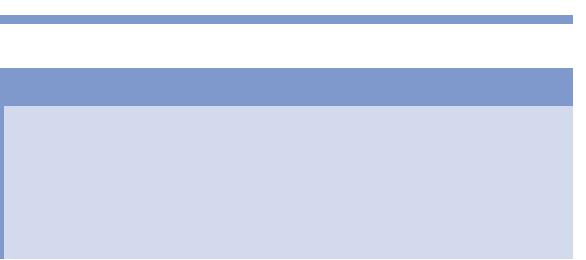
- perceived by adults with peanut allergy and the parents of peanut-allergic children. *Clin. Exp. Allergy* 30, 1135–1143.
- Pumphrey, R.S.H., Gowland, M.H., 2007. Further fatal allergic reactions to food in the United Kingdom, 1999–2006. *J. Allergy Clin. Immunol.* 119, 1018–1019.
- Rona, R.J., Keil, T., Summers, C., et al., 2007. The prevalence of food allergy: a meta-analysis. *J. Allergy Clin. Immunol.* 120, 638–646.
- Sampson, H.A., 2004. Update of food allergy. *J. Allergy Clin. Immunol.* 113, 805–819.
- Sampson, H.A., 2005. Food allergy: accurately identifying clinical reactivity. *Allergy* 60 (Suppl. 79), 19–24.
- Sampson, H.A., Munoz-Furlong, A.,

Keeping older people healthy	593
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Restless legs syndrome	608
Postural ankle oedema	609
Elder abuse	610
Sex and the elderly	611
Legal aspects	612
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- \* Continue screening programmes for mammography and cervical screening until older age. There is little evidence that screening is no longer worthwhile and most programmes recommend continuing to age 75 years, although in the UK routine screening ends at 65.
- \* Screening for, and management of, hypertension in particular and cardiovascular disease in geneb5.393n04(5.393nome)Tgr335(proim2(peanting))TfGS2g

more than occasionally report that they are 'problem drinkers' and males more so than females (

---



- (e) half of the women and a quarter of the men aged 85 years and over were not able to cook a main meal alone;
  - (f) only one in 10 received 'meals on wheels'.
- \* Assess the risk of dietary deficiencies in older patients especially those with chronic diseases, poor dentition, poor mobility, on low incomes, and housebound.
  - \* Have a low threshold for checking the vitamin B<sub>12</sub> status of older people especially if they develop neuropsychiatric symptoms (see



- | There is considerable variation in the availability of services for older people internationally and within countries, both in formal and informal provision. Generally, there is a multitude of services available aimed at either maintaining function or providing rehabilitation.
- | Services can be accessed either by direct referral or through specialist geriatric services.

|





- | A change in mental or physical status of usually well independent older people should be taken seriously and treated urgently. Symptoms of serious illness are often masked and fever is seldom higher than 37.5 C even in overwhelming infection.
  - | Acute change can be due to serious disease without overt symptomatology related to that disease. Confusion can be as simple as 'the patient has suddenly changed, something is wrong, the level of function has deteriorated'.
- |

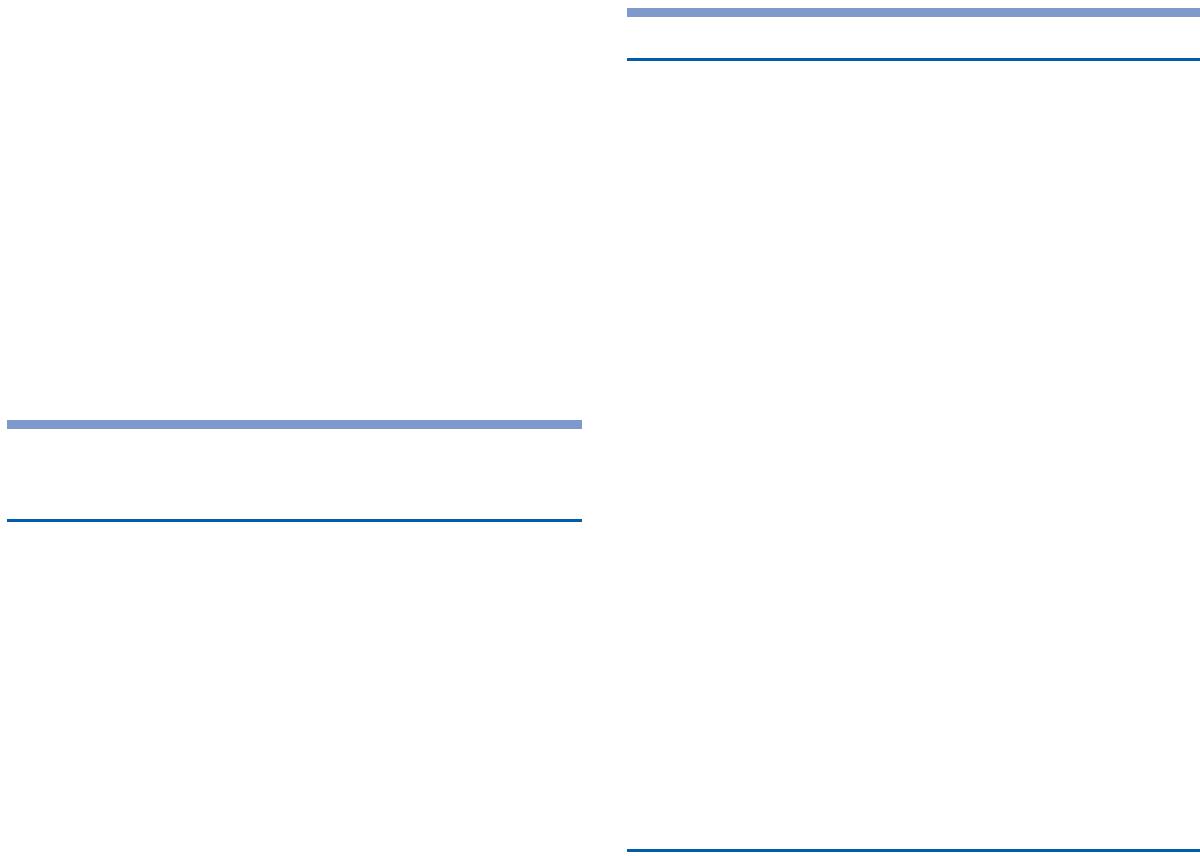








### Vascular dementia

- Accounts for 10% of dementia cases, although 29–41% of dementia cases autopsied have some vascular pathology.
  - Stepwise progression.
  - Bilateral neurological signs.
  - A history of cardiovascular disease suggests vascular dementia.
  - Risk factors, or a history of risk factors
- 
- A series of five horizontal lines of varying lengths and colors (blue and dark blue) are positioned on the right side of the page, creating a decorative border.



Cholinesterase inhibitors have been shown to improve cognition and global functioning in patients with Alzheimer's disease. The improvements are

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risperidone. Their use is associated with a small increase in the risk of cerebrovascular disease and death. This risk may be greater with risperidone than with haloperidol but the latter is more likely to cause sedation

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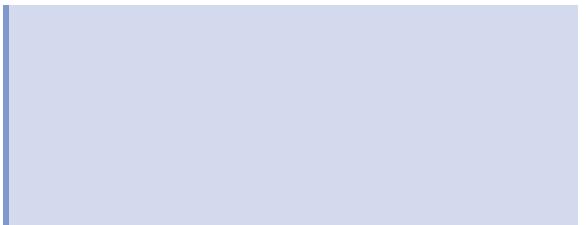
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- Multifactorial intervention is more effective than single intervention in preventing future falls, with a RR of 0.73 (95%CI 0.63 to 0.85) for unselected older people and 0.60 (95%CI 0.50 to 0.73) for those in residential care (Gillespie, Gillespie, Robertson, et al. 2003).
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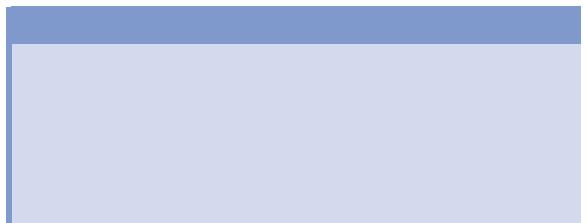


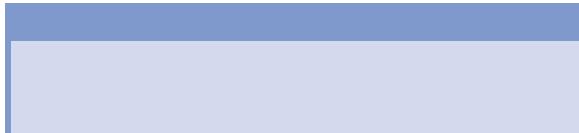


House of Commons Health Committee. Elder Abuse,



- | Sexual activity is common in the elderly with studies indicating at least 50% of 60–90-year-olds



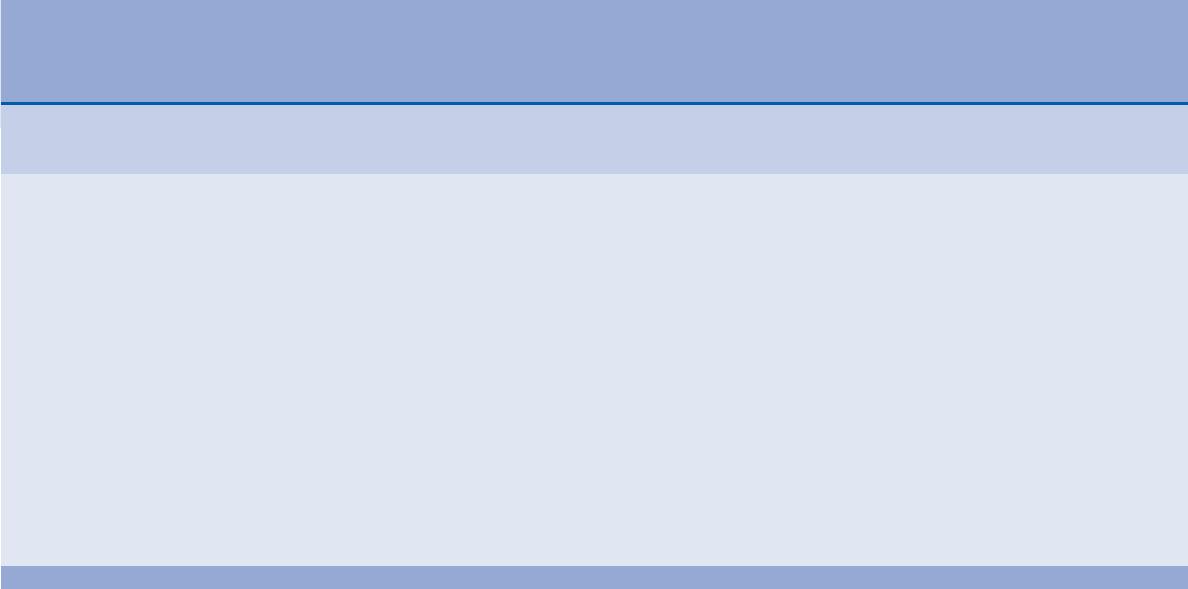








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The GP needs to become familiar with the medical condition that has caused the disability. Where the condition is a rarity, the GP will not gain the confidence of the family without this knowledge and will not be able to take a proactive role.

When making an assessment, check the following:

(a)

settings. GPs need to be familiar with the provision in their local area. Awareness of the eligibility criteria of the different services are essential in managing patients' expectations.

(a) Social Services

---

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Cosyfeet, 5 The Tanyard, Leigh Road, Street,  
Somerset BA16 0HR, tel. 01458 447275. Email:  
[comfort@cosyfeet.co.uk](mailto:comfort@cosyfeet.co.uk). Website: [www.cosyfeet.com](http://www.cosyfeet.com)

www.makoa.org/clothing.htm is a website listing  
approx 20 suppliers of adapted clothing

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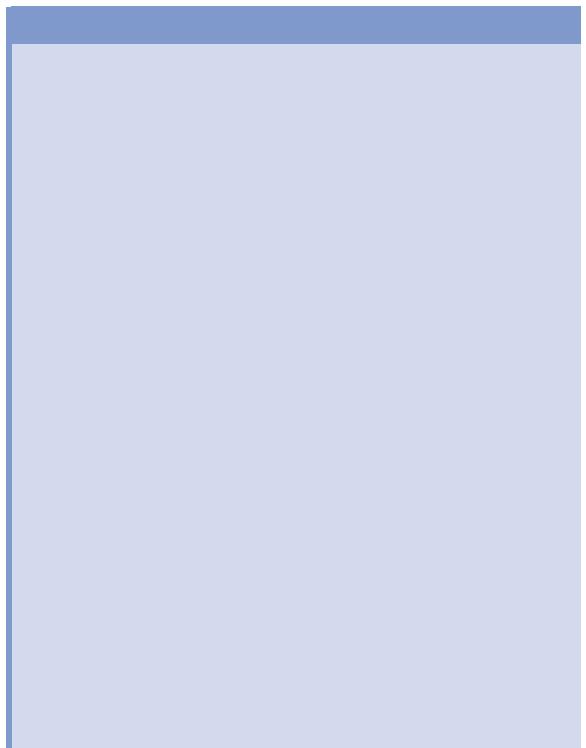
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16–17-year-old disabled young people for their own services;

- (d) gives local authorities a power (not a duty) to offer vouchers for short-term breaks.
- 









- (m) Depression: appears to be more common.  
Exclude hypothyroidism.
- (n) Bereavement:



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Howe, T.E., Rochester, L.,  
Jackson, A., et al., 2007. Exercise





\* Admit for transfusion only if the patient is

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**ANSWER**

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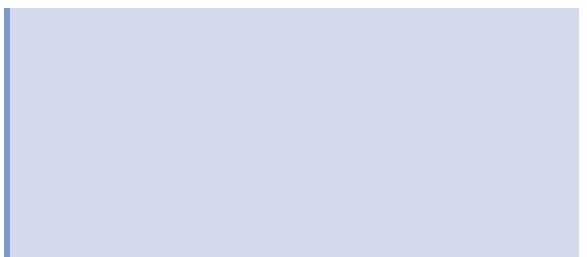
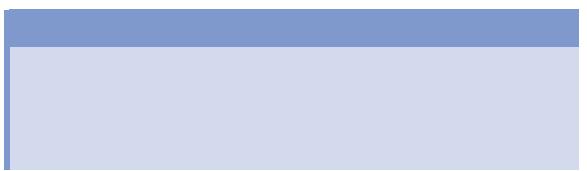
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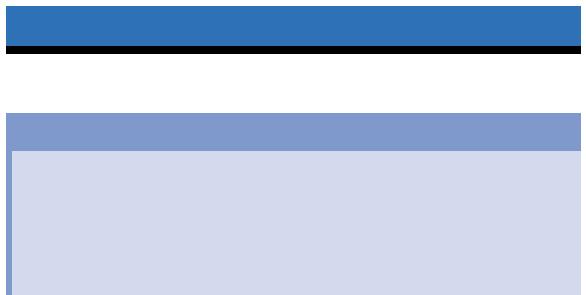
- \* Give oral folic acid during times of stress: infection, other illnesses, pregnancy, poor nutrition.
- \* Avoid giving iron and warn the patient not to let any other doctor give iron because of the mild anaemia.
- \* Discuss the implications for having children, if appropriate. Briefly, there is only a problem if the partner is also a carrier of the trait. If so, there is a 1 in 4 chance of a child with thalassaemia disease, a 1 in 2 chance of a child with the trait, and a 1 in 4 chance of a normal child. Refer for genetic counselling if both partners are known to have the trait.



It is estimated that there are about 12,000 people with sickle-cell disease in the UK (Yardumian and Crawley 2001).

- \* Screen potential carriers antenatally, see page 380. In the UK all babies are screened at birth.
- \* Refer to hospital urgently any patient with sickle-cell disease who presents with:

(a)



|



et al.

#### Practicalities

Timing and frequency of prothrombin times

Patients should take their warfarin in the evening  
and have blood taken in the morning. Prothrombin

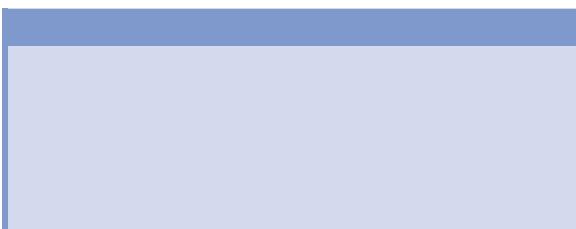


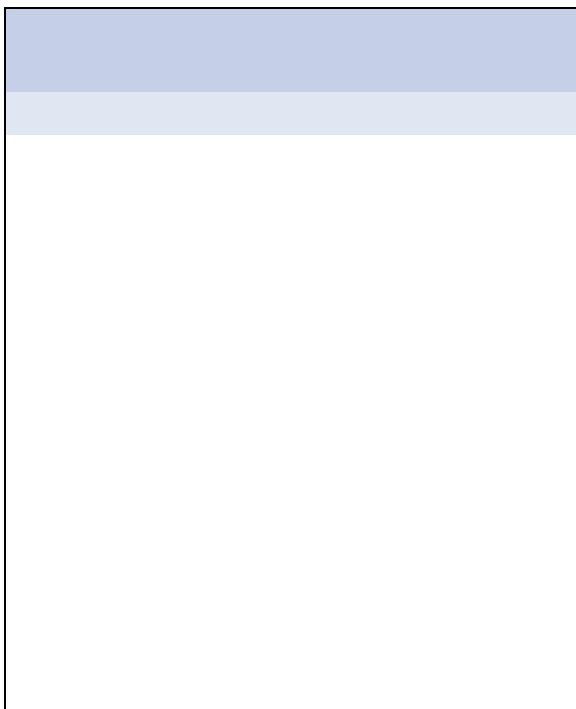
- \* If there is likely to be a delay give phytomenadione (vitamin K<sub>1</sub>) 5–10 mg by slow intravenous injection.
  - (b) INR > 8.0, no bleeding or minor bleeding
    - \* Stop warfarin, measure the INR every 2–3 days, restart when INR < 5.0.
    - \* If there are other risk factors for bleeding give
-

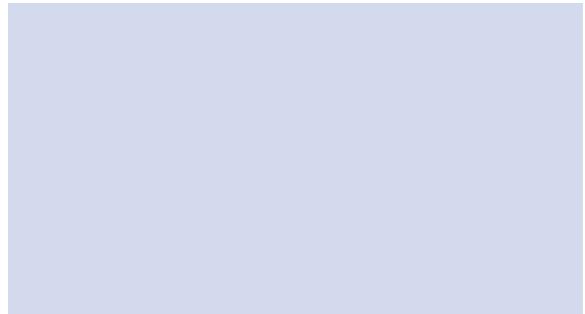
- London. Available on [www.dh.gov.uk/cancer/referral.htm](http://www.dh.gov.uk/cancer/referral.htm).
- DTB, 1995. Management of patients with thrombophilia. *Drug Ther. Bull.* 33, 6–8.
- DTB, 1992. How to anticoagulate. *Drug Ther. Bull.* 30, 77–80.
- Elis, A., Ravid, M., Manor, Y., et al., 1996. Clinical approach to "idiopathic" normocytic-normochromic anemia. *J. Am. Geriatr. Soc.* 44, 832–834.
- Goddard, A., McIntyre, A., Scott, B., 2000. Guidelines for the management of iron deficiency anaemia. British Society of Gastroenterology.

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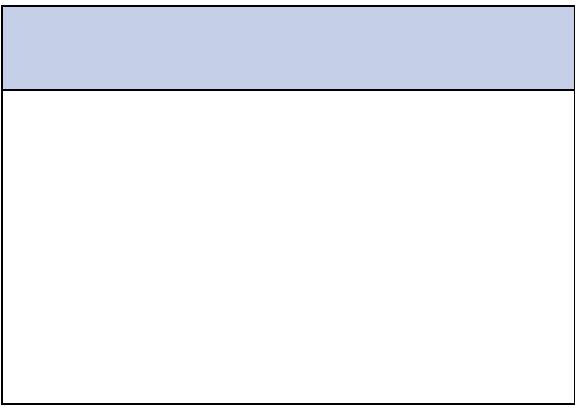
Cancer 643  
Breast cancer 644  
Ovarian cancer 645  
Oesophageal cancer 646











However, there is no evidence that the lead time provided by monitoring confers any survival benefit.

- \* Examine the liver for metastases.

British Colostomy Association, 15 Station Road,







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- (b) avoid talc which may irritate and increase the skin reaction to radiotherapy;  
(c) wear loose clothing made with natural fibre;  
(d) avoid sun exposure of the treatment area and protect with sunscreen cream.
- 
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- 

National Council for Palliative Care. 2003.  
Guidelines for Managing Cancer Pain in Adults, 3rd  
edition. Can be ordered from [www.ncpc.org.uk](http://www.ncpc.org.uk) (choose



CancerBACUP (British Association for Cancer United Patients), 3 Bath Place, Rivington Street, London EC2A 3RJ, tel. 0808 800 1234; [www.cancerbacup.org.uk](http://www.cancerbacup.org.uk)

Cancerhelp (produced by Cancer Research UK) for patients and families. [www.cancerhelp.org.uk](http://www.cancerhelp.org.uk)

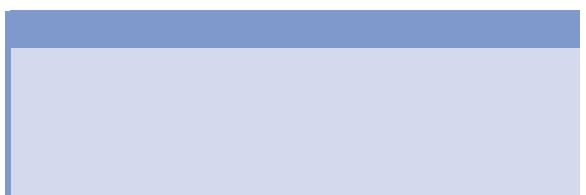
American Cancer Society. [www.cancer.org](http://www.cancer.org)

Mywavelength. This is a free, web-based support

for the terminal stage. Encourage patients and relatives to visit the hospice early in the illness. Remember, however, that most patients in the UK wish to die at home, although only a quarter do so (Thorpe 1993).

The terminal phase may be recognized first by the patient themselves. Indicators are:

(a)



to discuss use of a drug outside its licence with a specialist. When using a drug outside its licence, a doctor should:

---

---

- \* Assess the way that the patient's emotional and spiritual state is contributing to their perception of pain. Patients will often try to hide their feelings from their family, and even from their doctors. Ask specific questions, rather than relying on an unspoken assessment. For instance, asking 'do you feel low most of the time?' and 'do you feel tense, or restless or frightened most of the time?' will allow the patient to admit to depression and anxiety if they are present. A question like 'how has this



hallucinations, myoclonus, nausea, sedation,  
and rarely respiratory depression.

~~Side effects~~

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\*

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2. Warn the patient that it will be several days before any benefit is felt; 50–90% of patients achieve at least 50% reduction in the severity of the pain (McQuay and Moore 1997). The NNT for antidepressants in neuropathic



- \* Do not increase the 24-hour opioid dose. The increase in side-effects may outweigh the benefit. Consider giving breakthrough analgesia as above before the patient is moved.
- \* Fentanyl lozenges. Start at 200 mcg regardless of the opioid dose. Analgesia starts after 5–15 minutes and lasts up to 2 hours.
- \* Consider co-analgesics.
- \* Physiotherapy. Refer to improve muscle tone and rehabilitation.
- \* Orthopaedic surgeon. Refer for surgical stabilization of the affected area. Internal stabilization of long bones may produce considerable benefit, even in advanced disease.



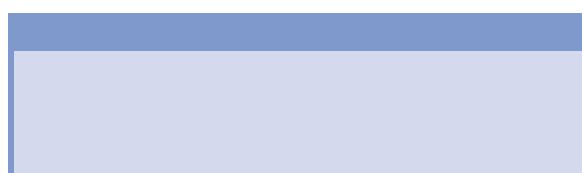
## **Switching to patches or syringe drivers**

Moving from oral drugs to a patch or to a syringe driver is never simple. Inexperienced GPs would do well to take specialist advice.

Fentanyl patches should only be used for patients whose pain is stable, because of the time taken to titrate the dose. When the patch is first applied it will take 12–18 hours before maximal analgesia is seen. The dose of the patch should not be increased until it is due to be changed, but an immediate



- \* Nasogastric suction should only be used in those being considered for surgery and those with





- \* Complicated delirium in the terminal days may need the addition of phenobarbital (200–600 mg daily) via a separate syringe driver.



Clinical Knowledge Summaries. 2009.

- \* Stridor from obstruction of the larynx or airway. Give high-dose dexamethasone (16 mg daily).
- \* Pleural or chest wall pain. Consider the need for radiotherapy or intercostal nerve block. Prescribe an NSAID unless already taken.
- \* Severe breathlessness and a sensation of drowning may be due to superior vena caval obstruction.
  - (a) Give high-dose oral steroids (stop after 5 days if not effective).
  - (b) Admit for radiotherapy if appropriate.
  - (c) Use low-dose morphine to relieve dyspnoea.
  - (d)

- (c) chewing unsweetened pineapple chunks  
(fresh or tinned) if the tongue is coated. The proteolytic enzyme annanase will clear the tongue in days.
- \* Foul smell. Use oral metronidazole 400 mg b.d. or rectal 500 mg b.d.

The combination of anorexia, muscle wasting and weakness and severe physical and mental fatigue

- \* Skin dryness. Maintain skin hydration with a moisturizer.
  - \* Breaks in the skin. Protect them from infection with antiseptic cream.
  - \* Cellulitis. Treat with elevation and antibiotics.
- 
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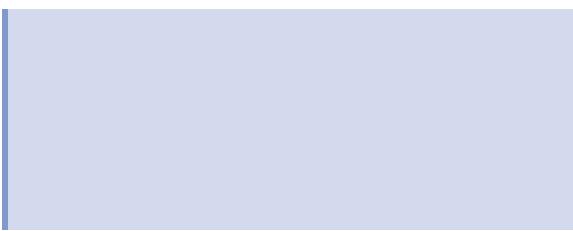
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American Joint Commission on  
Cancer and International Union  
Against Cancer: <http://imagingis.com/breasthealth/staging.asp>.  
Accessed January 2010.

Bredin, M., Corner, J.,

Krishnasamy, M., et al., 1999.  
Multicentre randomised  
controlled trial of nursing  
intervention for breathlessness in





guide the physician in the tailoring of medication as well as demonstrating improvement to the patient and carer, if there has been any. The simplest way to assess and document the severity of pain is to ask the patient to score it on a scale of 1 to 10, either verbally or by drawing a 10 cm line, marked

---





Patients often describe this as 'the worst pain in the world' (Bennetto, Patel and Fuller 2007).

\* Refer patients with atypical symptoms; or who are relatively young; or who do not respond to first line medical treatment. They need imaging





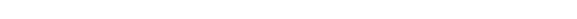
50 -

s o r s

- (f) the person is vulnerable by reason of personality, previous mental illness or bereavement, or poor physical health.

Consider it when:

- (a) the bereaved appears to be stuck in a state of denial, anger or depression, rather than moving towards acceptance. Most people will have overcome denial by 2 months, anger by 6 months and depression by 12 months, although these timings are a crude guide only;









**s** **s** **s**

---

- \* Old age should only be given as the sole cause of death in very limited circumstances. These are that:

(a)

- Ic. Community acquired pneumonia with severe sepsis.
- II. Immobility, polymyalgia rheumatica, osteoporosis.
- n If a HCAI contributed but was not part of the direct sequence it should be included in part II, e.g.
  - Ia. Carcinomatosis and renal failure.
  - Ib. Adenocarcinoma of the prostate.
- II. Chronic obstructive airways disease and catheter associated Escherichia coli urinary tract infection.
- \* Pneumonia. Specify, where possible, whether it was lobar or bronchopneumonia and whether primarily hypostatic, or related to aspiration and the organism involved, e.g.
  - Ia. Pneumococcal pneumonia.
  - Ib. Influenza A.
  - Ic.
- II. Ischaemic heart disease.

\*

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(c) reminding oneself of why the change was



The COMA report recommends major changes in the national pattern of food consumption (Report of the Cardiovascular Review Group of the Committee on Medical Aspects of Food Policy (COMA) 1994).

- | A higher fruit and vegetable intake (five or more servings daily) helps provide protection against:
  - (a) cardiovascular disease; increasing fruit and vegetables by two servings per day may decrease cardiovascular risk by 30%;
  - (b)



- | There is now considerable evidence that lifestyle modifications (exercise and diet) can reduce the progression of impaired glucose tolerance to diabetes and hence reduce these risks

(



Wannamethe, Walker,



- | Fine-woven cotton clothing and hats also screen the skin.
- | Exposure to sunlight should be rationed and strong midday sun avoided.
- | Children should be protected against strong



Health, London. Available: [www.advisorybodies.doh.gov.uk](http://www.advisorybodies.doh.gov.uk)  
(search for 'COC/04/S5').

Cook, D.G., Strachan, D.P., 1999.  
Summary of effects of parental  
smoking on the respiratory health  
of children and implications for  
research. *Thorax* 54, 357–366.

Copas, J.B., Shi, J.Q., 2000. Reanalysis  
of epidemiological evidence on  
lung cancer and passive smoking.  
*BMJ* 320, 417–418.

Davey Smith, G., Shipley, M.J.,  
Batty, G.D., et al., 2000. Physical  
activity and cause specific  
mortality in the Whitehall study.  
*Public Health* 114, 308–315.

Davis, R.M., 1994. Passive smoking:  
history repeats itself. *BMJ* 315,  
961–962.

Department of Health, 1998.  
Nutritional Aspects of the  
Development of Cancer. HMSO,  
London.

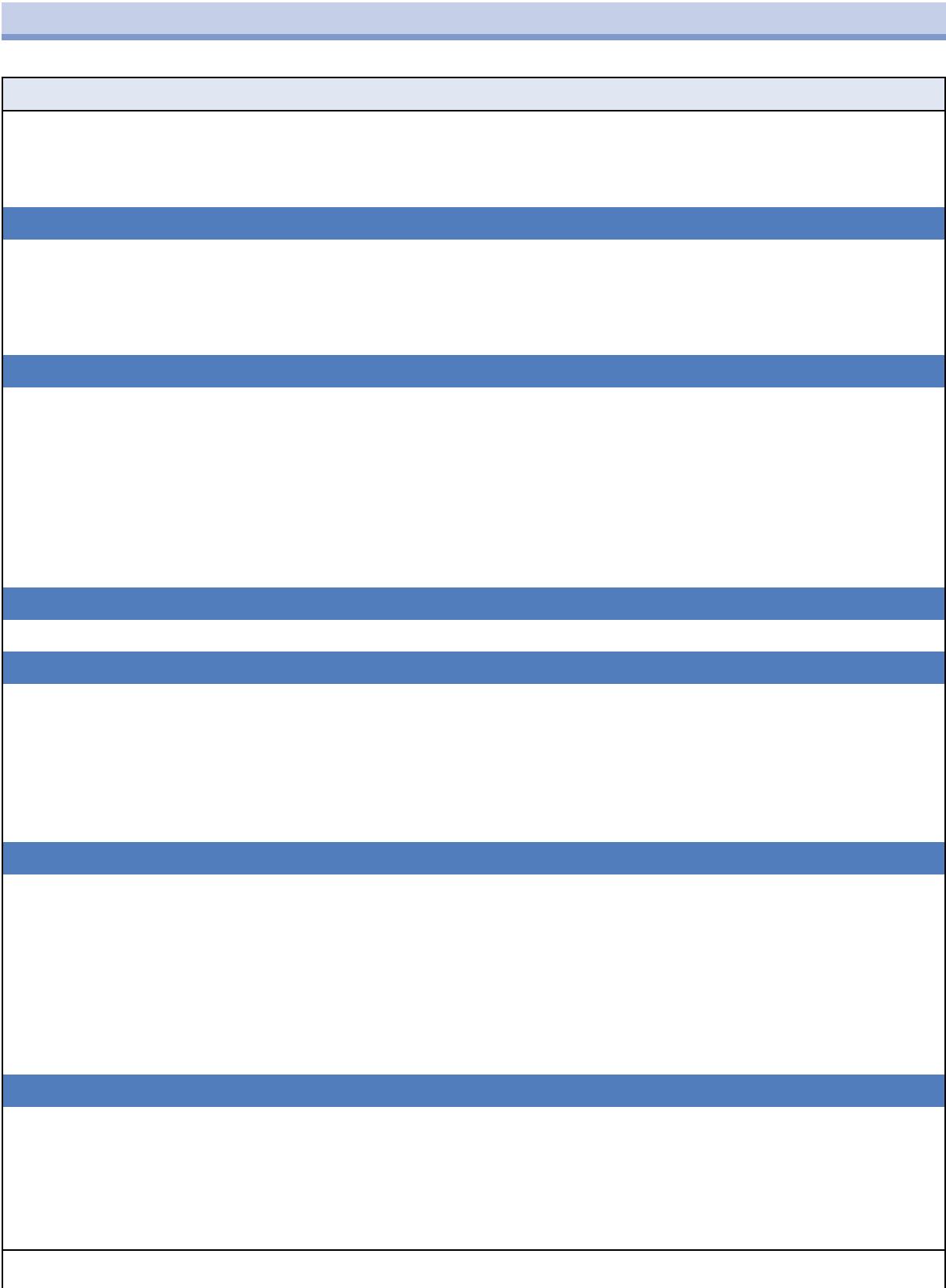




Gastroenteritis (Norwalk virus)	4–77 hours	0–3 days	3 days after onset
Gastroenteritis (unidentified)	N/A	N/A	For duration of the illness
Giardiasis	5–20 days	2 weeks	24 hours from last diarrhoea
Salmonellosis	4 hours to 5 days	Adults 4 weeks (median). Children under 5 up to 1 year	Children under 5: 1 negative stool. Others, until 24 hours after last diarrhoea
Typhoid and paratyphoid	3–56 days	2 weeks to indefinite	Until 24 hours after last diarrhoea
Chickenpox	11–20 days		

This schedule is for an adult who has been fully immunised as a child according to the UK recommendations. Few travellers will need all the immunisations below; they should only be given if appropriate to the travel planned.

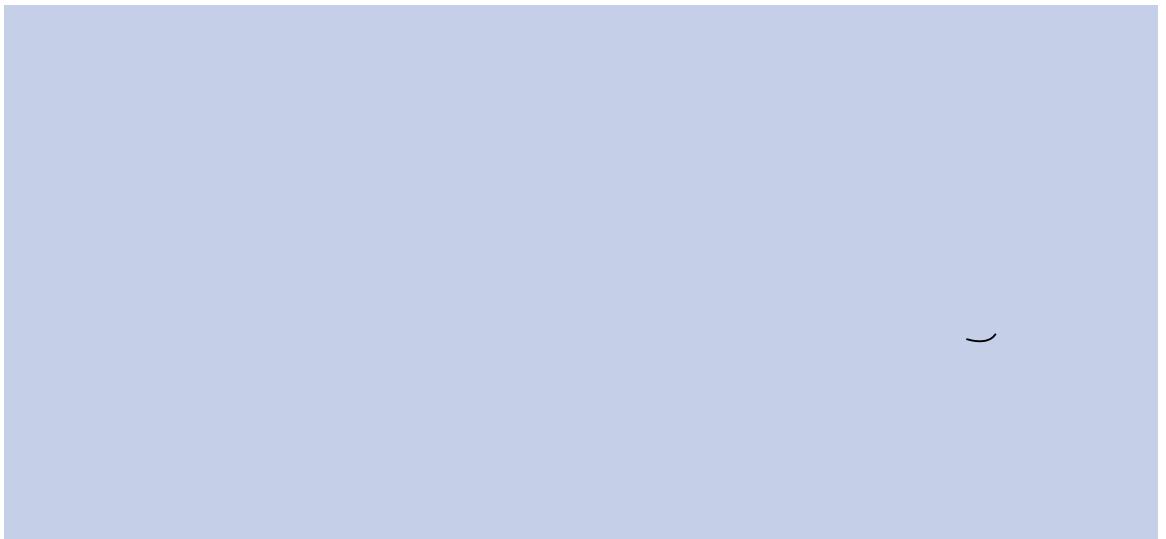
Day 0	Rabies, Japanese encephalitis, tick-borne encephalitis, hepatitis B
Day 7	Rabies, Japanese encephalitis
Day 14	Tick-borne encephalitis
Day 28	Rabies, Japanese encephalitis, hepatitis B
At some point in the above schedule (either together or spread out over the month). Immunisation early in the month (at least 1 week before departure) will allow time for immunity to develop	BCG, cholera, hepatitis A, meningococcal ACWY, polio, tetanus and diphtheria (as Td), typhoid, yellow fever
If exposure to risk continues, further immunisations against hepatitis B will be needed at 2 months and at 1 year from the first dose, and against tick-borne encephalitis at 9 months to 1 year after the last dose.	



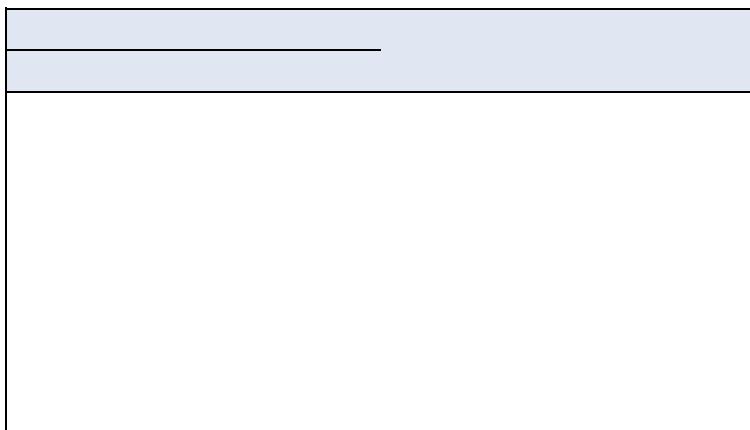


Personal and social behaviour		Becoming egocentric, clinging and resistant Loves domestic mimicry Definitely stopped mouthing and casting (by 18 months) Helps undress
Shows affection and may be shy Indicates wants, points, claps hands (10–18 months) Mouthing stops (12–15 months) Enjoys casting (12–15 months) May manage cup and spoon with spills (10–17 months)		

--



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0.80	32	0.41	0.46
0.90	35	0.56	0.64
1.00	39	0.75	0.86
1.10	43	0.98	1.11
1.20	47	1.24	1.43
1.30	51	1.55	1.79
1.40	55	1.90	2.20
1.50	59	2.29	2.68
1.60	63	2.73	3.22
1.70			







## Management of acute severe asthma in adults in general practice

Many deaths from asthma are preventable. Delay can be fatal. Factors leading to poor outcome include:

Regard each emergency asthma consultation as for acute severe asthma until shown otherwise.

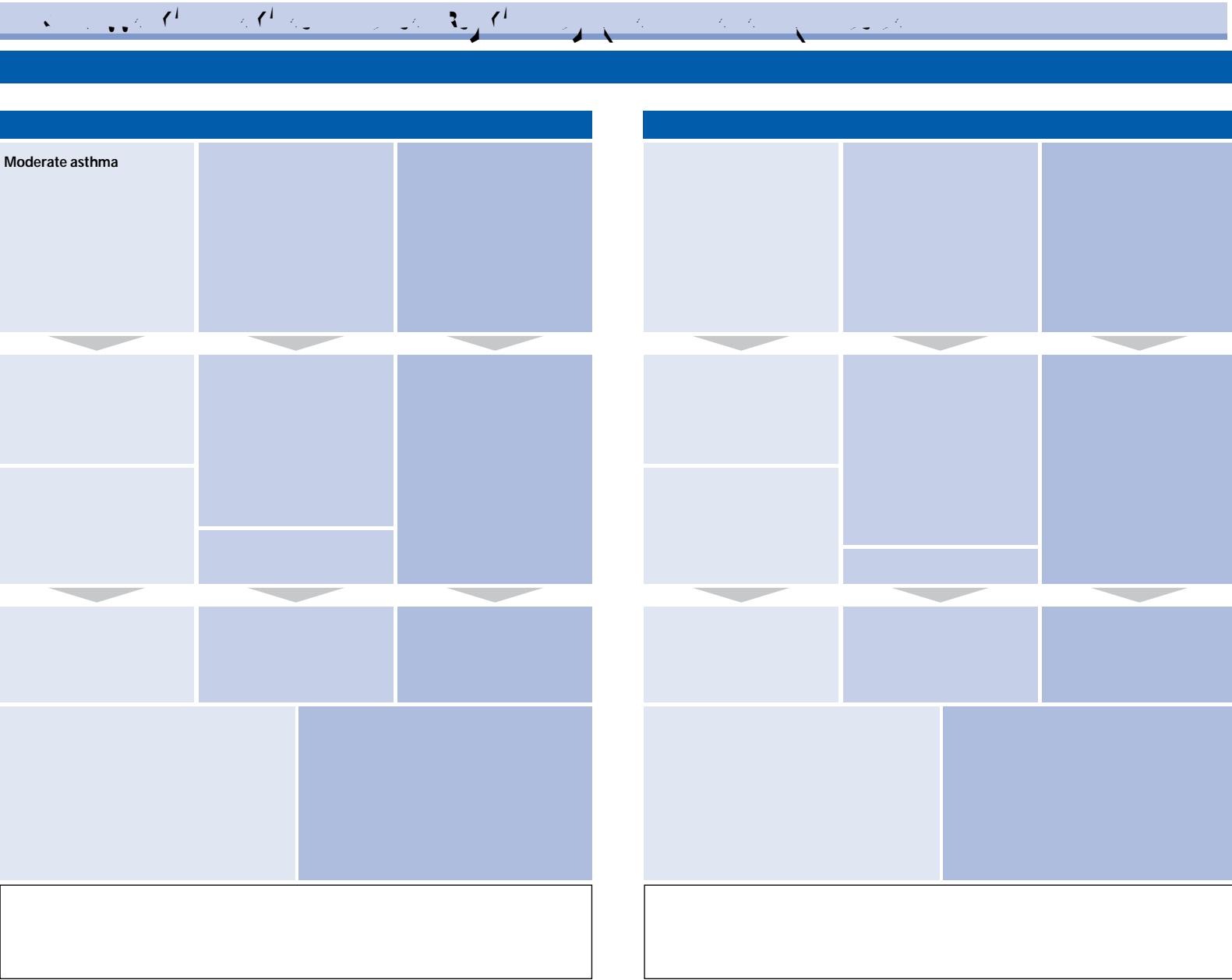
Assess and record:

**Caution:** Patients with severe or life threatening attacks may not be distressed and may not have all the abnormalities listed below. The presence of any should alert the doctor.

Moderate asthma

Treat at home or in surgery and  
ASSESS RESPONSE TO TREATMENT

Consider admission



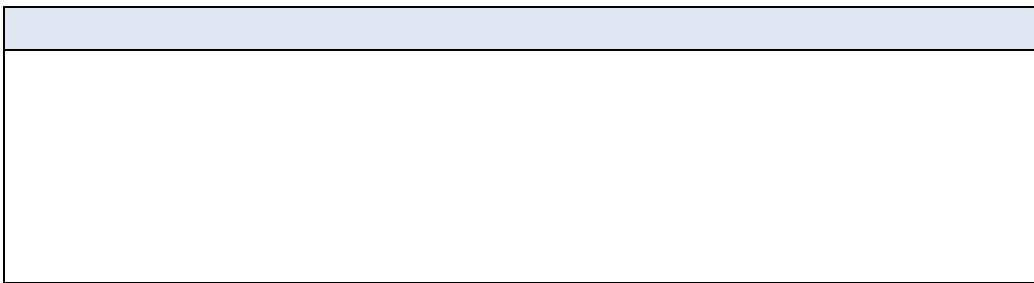




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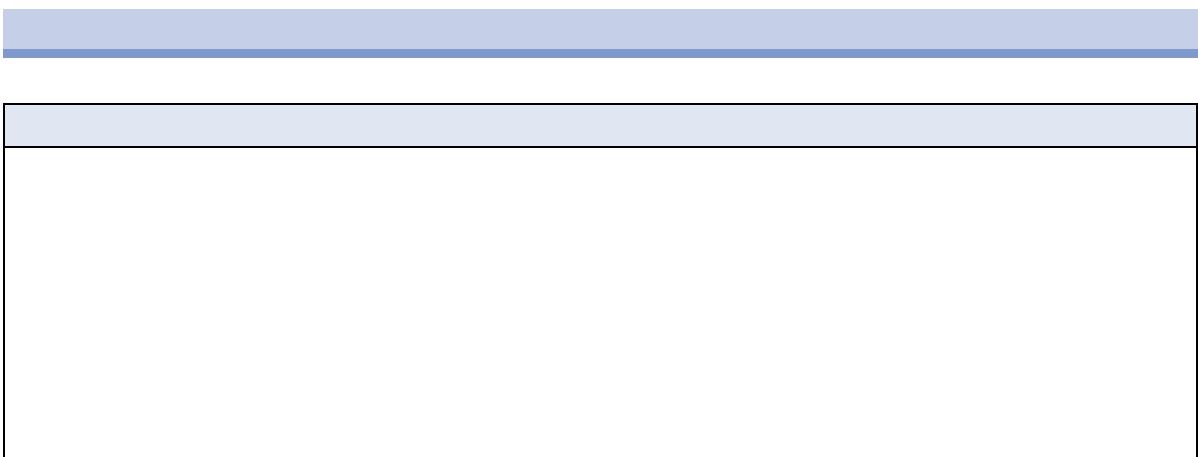
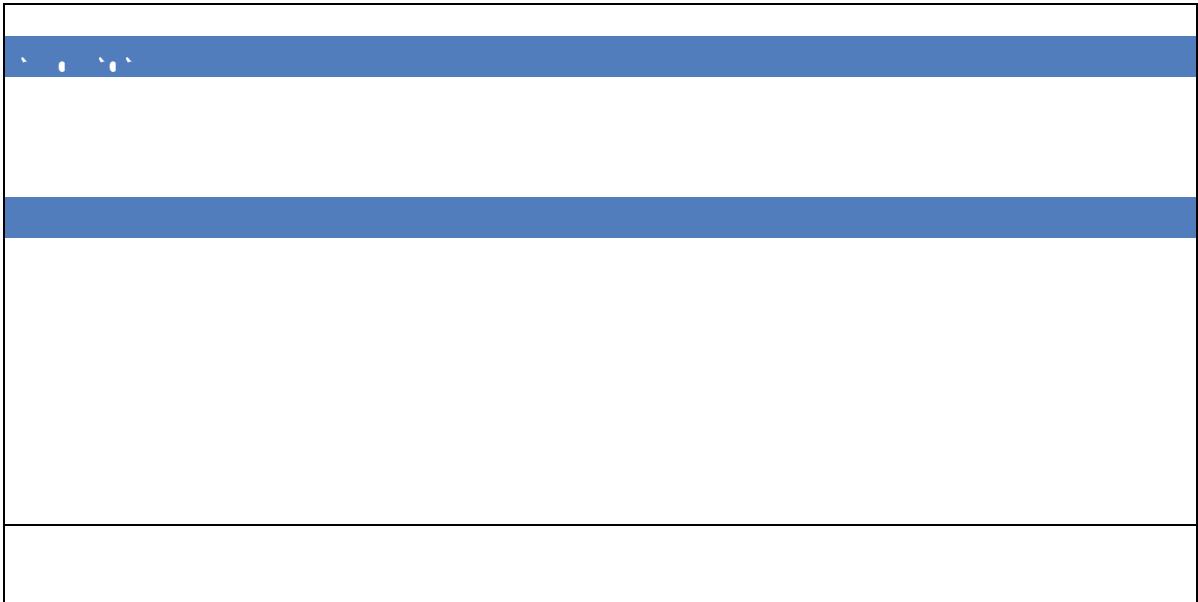
WBC < 3.5 10





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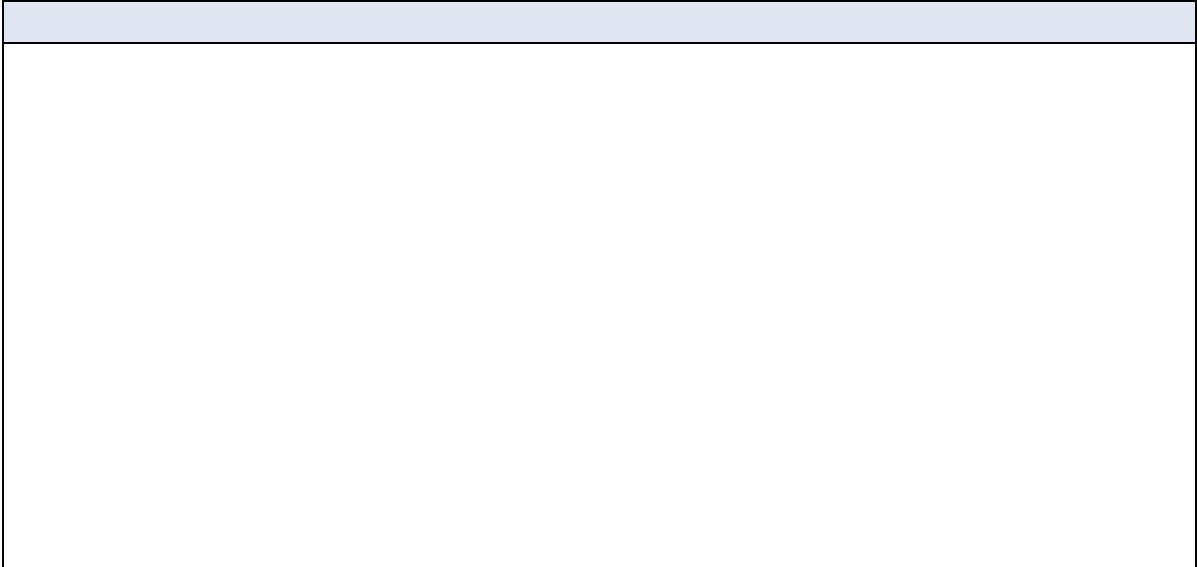
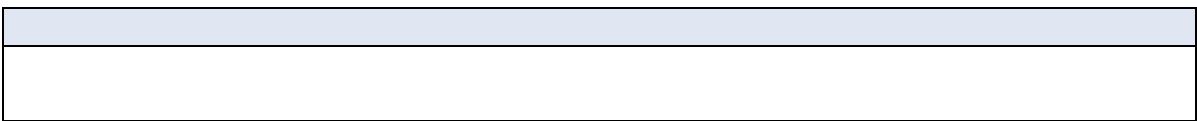
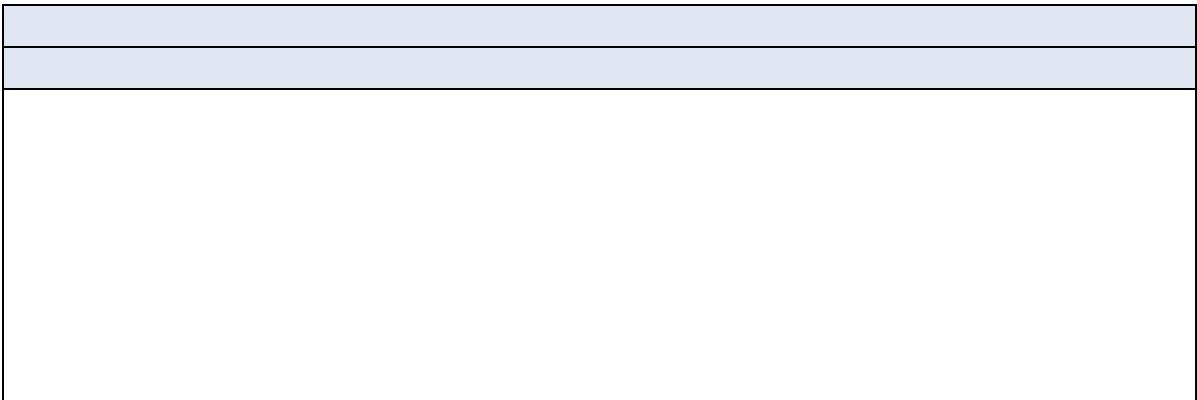
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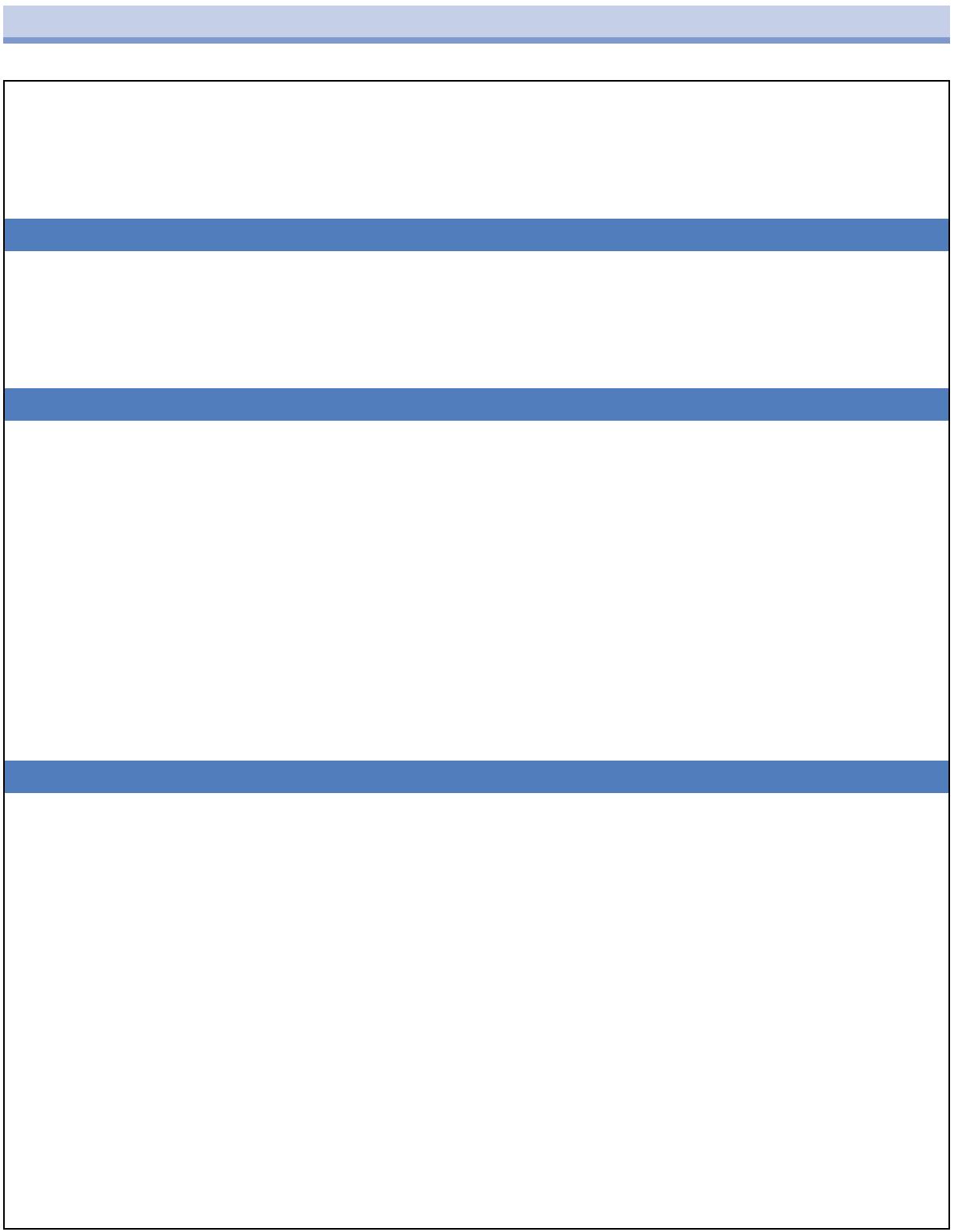
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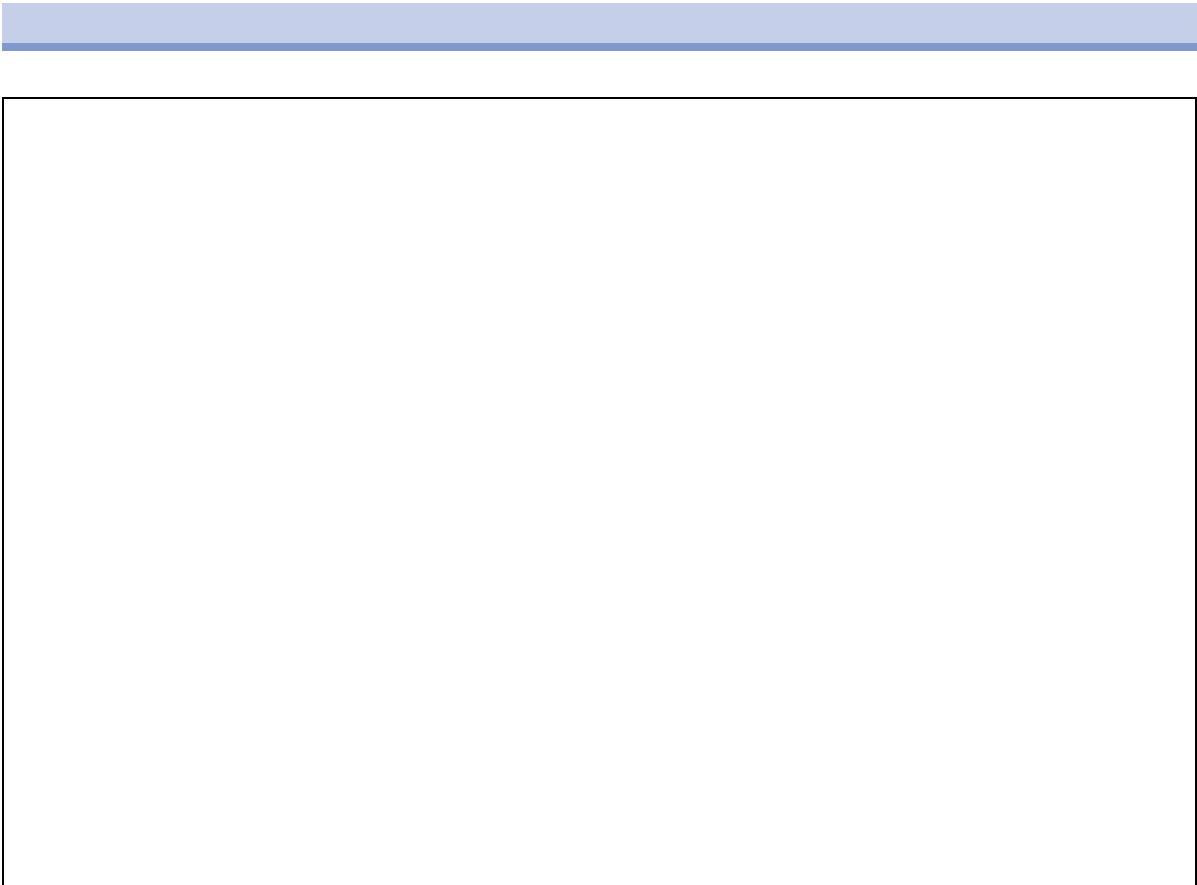
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January		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	January
October		8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1	2	3	4	5	6	7	November











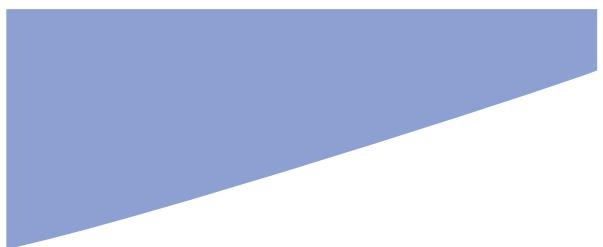
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Box mass index  $\frac{1}{4}$  W/H<sup>2</sup>



Reference ranges vary according to laboratory and test method. The following are given as typical ranges but if the laboratory performing the test gives a range that differs from these it should be used instead. The range will also vary according to age and gender.

Serum or plasma	Immunoglobulins:	
Acid phosphatase:	IgG	6–13g/L
total	IgM	0.5–2.0 g/L
prostatic	IgA	1.0–4.0 g/L
ACTH	Lactate dehydrogenase	70–250 iu/L
Alkaline phosphatase		

Haemoglobin	13.5–18.0 g/dL (men) 11.5–16.0 g/dL (women)
MCV	82–98 fL
MCH	26.7–33.0 pg
MCHC	31.4–35.0 g/dL
WBC	3.2–11.0 $10^9/L$
Neutrophils	1.9–7.7 $10^9/L$
Monocytes	0.1–0.9 $10^9/L$

Reproduced from Working Group of the Resuscitation Council (UK). Emergency treatment of anaphylactic reactions. Guidelines for healthcare









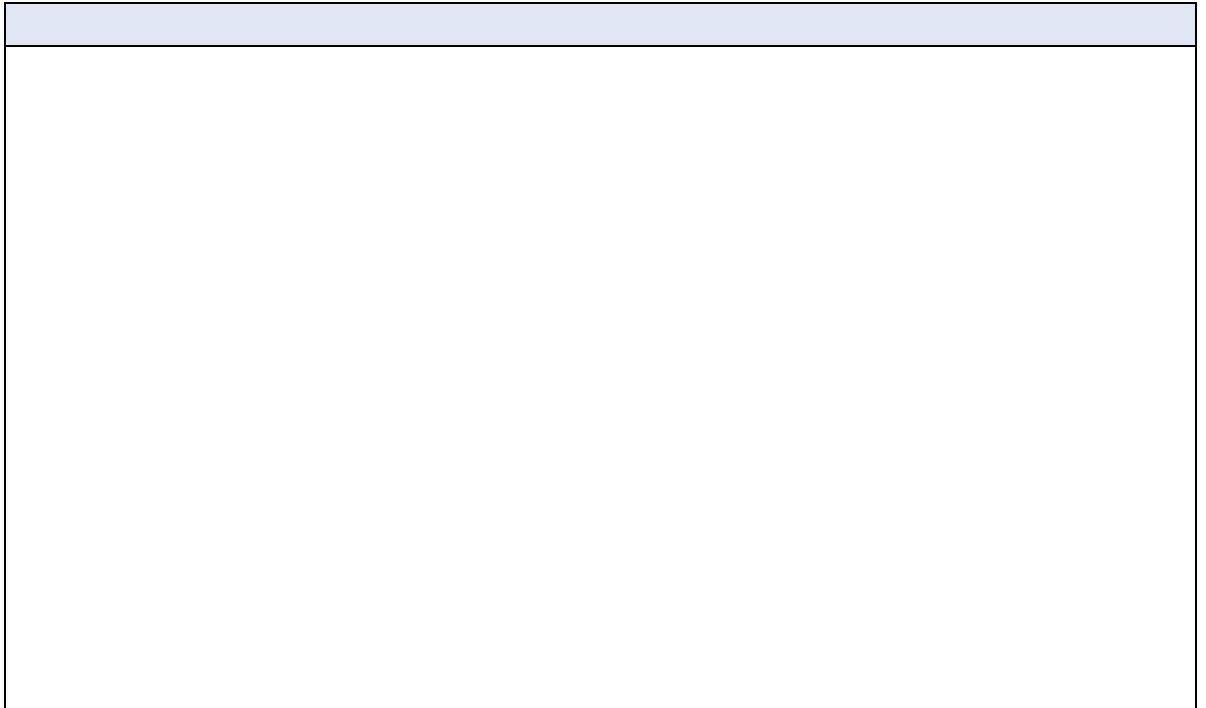
Professor Pamela Eakin, reproduced with permission.

Score the patient under the following nine headings. A score < 75 suggests moderate disability; < 50 suggests severe disability.

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5 ¼







Diamorphine and metoclopramide	1200 40	2100 70	2550 85	Mixture can be irritant dilute to largest possible volume
Diamorphine and midazolam	400 16	700 28	850 34	–
Diamorphine and octreotide	200 0.9	350 1.6	425 1.9	–
Diamorphine and ondansetron	40 5	70 9	85 11	

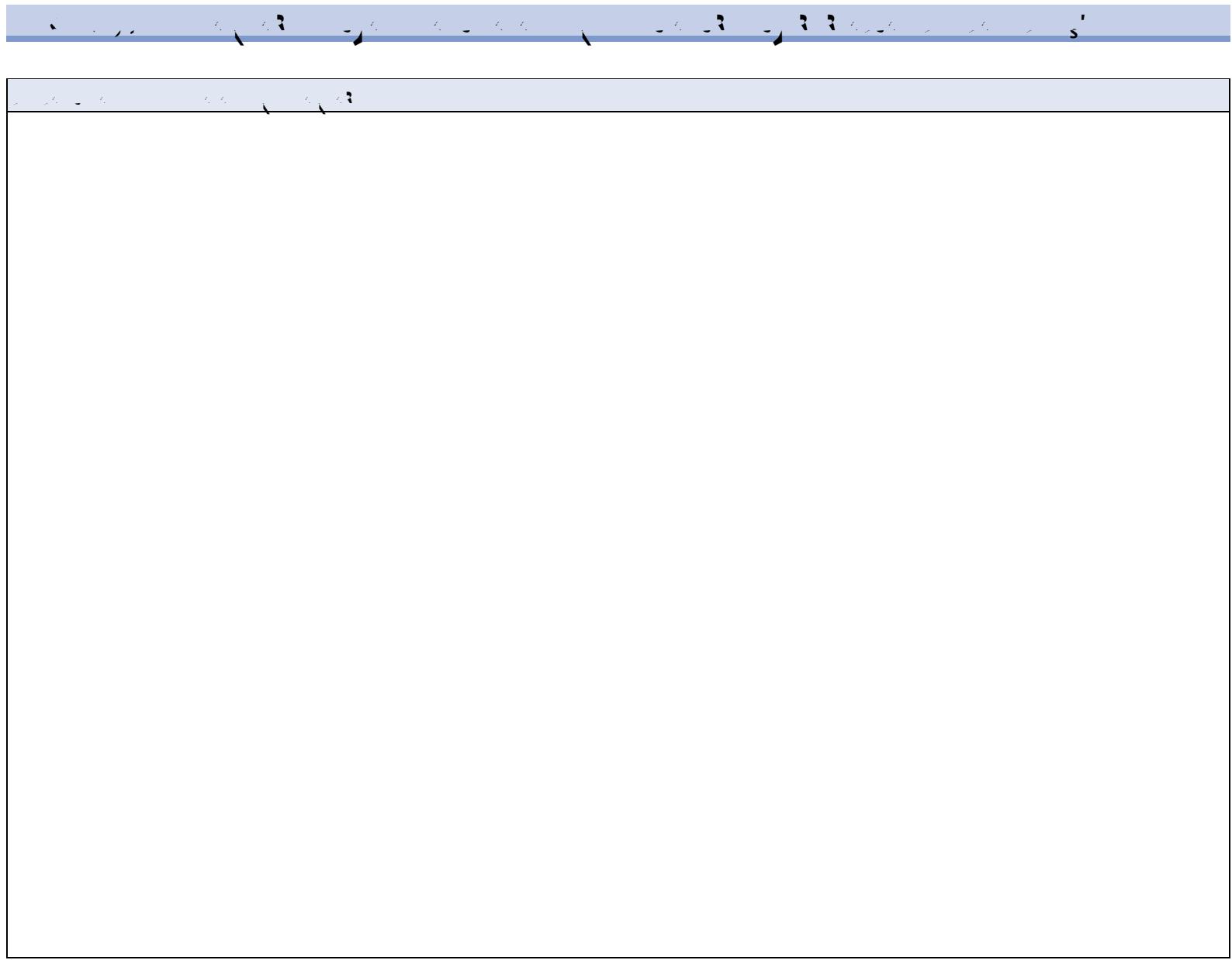
Three drug combinations for subcutaneous infusion which are stable for 24 hours

Diluent: Water for injections BP

Diamorphine and cyclizine and

Lung cancer	Urgent referral for chest X-ray <ul style="list-style-type: none"><li>  Haemoptysis</li><li>  Unexplained or persistent (more than 3 weeks):<ul style="list-style-type: none"><li>- cough</li><li>-</li></ul></li></ul>
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Head and neck cancer

Urgent referral:

|

	<ul style="list-style-type: none"> <li>- painful</li> <li>- increasing in size</li> <li>- deep to fascia, fixed or immobile</li> <li>- recurrence after previous excision</li> </ul>
	<ul style="list-style-type: none"> <li>I Suspected Kaposi's sarcoma in a patient who has HIV</li> <li>I Increasing, unexplained or persistent bone pain or tenderness, particularly pain at rest, (especially if not in the joint) or an unexplained limp. Investigate urgently first</li> </ul>
Children's cancers	
General	<p><b>Urgent referral</b></p> <ul style="list-style-type: none"> <li>I When a child presents 3 or more times with the same problem and investigation reveals no clear diagnosis</li> <li>I Persistent back pain after investigation and taking parental anxiety into account</li> </ul>
Leukaemia	<ul style="list-style-type: none"> <li>I Unexplained petechiae (refer immediately)</li> <li>I Hepatosplenomegaly (refer immediately)</li> <li>I Take blood for FBC and film (and refer urgently if positive) if any of the following is present:           <ul style="list-style-type: none"> <li>- fatigue</li> <li>- pallor</li> <li>- unexplained irritability</li> <li>- unexplained fever</li> <li>- persistent or recurrent upper respiratory tract infections</li> <li>- generalised lymphadenopathy</li> <li>- persistent or unexplained bone pain</li> <li>- unexplained bruising</li> </ul> </li> </ul>
Lymphoma	<ul style="list-style-type: none"> <li>I</li> </ul>

Children of any age with any of the following (immediate or urgent referral):

- new-onset seizures
- cranial nerve abnormalities
- visual disturbance
- gait abnormality
- motor or sensory signs
- unexplained deteriorating school performance or developmental milestones
- unexplained behavioural and/or mood changes
- | Children age 2 and older, and young people, with persistent headache where you cannot carry out an adequate neurological examination
- | Children < 2 years old with any of the following:
  - abnormal increase in head size
  -

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